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# Ohio Medicaid

## Pharmacy Benefit Management Program

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Department of  
Medicaid

# Unified Preferred Drug List

**Medicaid Fee-for-Service  
and Managed Care Plans**

Effective January 1, 2023

**AR** = Age Restriction   **QL** = Quantity Limit   **ST** = Step Therapy Required   **PA** = Clinical Prior Authorization Required   **BvG** = Brand Preferred Over Generic

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## Helpful Links

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### Prior Authorization (PA)

[Prior Authorization \(PA\) Information | pharmacy.medicaid.ohio.gov](#)

- **General Prior Authorization Requirements**
- **PA and Step Therapy Frequently Asked Questions (FAQ)**

### Drug Coverage

[Drug Coverage Information | pharmacy.medicaid.ohio.gov](#)

- **Drug Lookup Tool**
  - **UPDL Criteria**
  - **Quantity Limits**
  - **Preferred Diabetic Supply List**
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## General Information

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- The Statewide UPDL is not an all-inclusive list of drugs covered by Ohio Department of Medicaid.
  - Medications that are new to market will be non-preferred, PA required until reviewed by the Ohio Department of Medicaid Pharmacy and Therapeutics (P&T) Committee.
  - The document is listed in sections defined by therapeutic class. Drugs are listed by generic name if a generic is available unless the brand name of the drug is preferred. In most cases, when a generic for a brand-name drug is available, the generic drug will be preferred, and the brand name will be non-preferred. Some drugs may also require a specific manufacturer or the brand to be dispensed.
  - Ohio Department of Medicaid will only cover drugs that are part of the Medicaid Drug Rebate Program, with limited exceptions. This document may not reflect the most current rebate status of a drug (i.e., a drug may be listed on the document but is non-rebateable and therefore non-payable).
  - Some therapeutic categories are grandfathered. These categories will be denoted with an “\*” next to their title on the table on contents and their place within the criteria document.
  - Some therapeutic categories may have quantity limits on specific drugs detailed in the criteria document, however this is not an all-inclusive list. For a list of the quantity limits on specific drugs, please reference the [Quantity Limit Document found here: Quantity Limits Document | pharmacy.medicaid.ohio.gov](#)
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## Terminology/Abbreviations:

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**AR** (Age Restriction) – An edit allowing claims for members within a defined age range to be covered without PA

**BvG** (Brand Preferred Over the Generic) – The brand name drug is preferred over the generic equivalent

**PA** (Clinical Prior Authorization) – A prior authorization (PA) is required before the drug will be covered

**QL** ([Quantity Limit](#)) – A limit on the quantity that will be covered within a given time frame

**ST** (Step Therapy) – Drug requires a trial with one or more preferred drugs before being covered

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## New UPDL Criteria Format

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- Beginning January 2023 and with a few minor exceptions, all therapeutic categories have the same standardized outline format. The design of this new format is intended to have a cumulative approach bottom-to-top.

### Example Category

**LENGTH OF AUTHORIZATIONS:** X days or Initial: X days; Subsequent: X days (if different)

**GRANDFATHERING\*:**

Patients who have a claim for a non-preferred drug in the previous 120 days will be automatically approved to continue the drug. Patients who have taken the drug previously, but do not have claims history (e.g. new to Medicaid), will need to submit a prior authorization in order to continue coverage.

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**CLINICAL PA CRITERIA (if applicable):**

**“DRUG” CRITERIA (if applicable):**

**STEP THERAPY CRITERIA:**

- Must have had an inadequate clinical response of at least X days with at least X preferred drugs

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least X days with X preferred drugs
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**ADDITIONAL “DRUG” CRITERIA (if applicable):**

**ADDITIONAL INFORMATION (if applicable):**

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient’s response to treatment from baseline and/or attestation of clinical stabilization

**QL** – Drug: X doses per X days

**AR** – a PA is required for patients X years and older **OR** younger than X years

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## Interpretation of New UPDL Criteria Format

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- Beginning January 2023 and with a few minor exceptions, all therapeutic categories have the same standardized outline format. The design of this new format is intended to have a cumulative approach bottom-to-top. The following scenarios will aid in illustrating this point:

### Scenario 1: Clinical PA drug

- All Authorizations
- Clinical PA Criteria

### Scenario 2: Clinical PA drug with drug-specific criteria

- All Authorizations
- Drug-Specific Criteria

### Scenario 3: Step-Therapy drug

- All Authorizations
- Clinical PA Criteria (if applicable)
- Step Therapy Criteria

### Scenario 4: Non-Preferred drug

- All Authorizations
- Clinical PA Criteria (if applicable)
- Step Therapy Criteria (if applicable)
- Non-Preferred Criteria

### Scenario 5: Non-Preferred drug with drug-specific criteria

- All Authorizations
  - Clinical PA Criteria (if applicable)
  - Step Therapy Criteria (if applicable)
  - Non-Preferred Criteria
  - Additional Drug-Specific Criteria
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Analgesic Agents: Gout	
PREFERRED	NON-PREFERRED
Allopurinol <sup>QL</sup>	Colchicine Cap Mitigare <sup>BvG QL</sup>
Colchicine Tab <sup>PA QL</sup>	Gloperba Susp <sup>QL</sup>
Colcrys Tab <sup>PA QL</sup>	Uloric <sup>BvG</sup> Febuxostat
Probenecid <sup>QL</sup>	Probenecid/Colchicine <sup>QL</sup>
Probenecid/Colchicine <sup>PA</sup>	

[Link to Criteria: Analgesic Agents: Gout](#)

Analgesic Agents: NSAIDs	
PREFERRED	NON-PREFERRED
Celecoxib <sup>QL</sup>	Diclofenac/Misoprostol
Diclofenac IR, DR, ER, Gel 1%	Diclofenac Patch 1.3%
Etodolac	Diclofenac
Fenoprofen 600mg	Elyxyb
Flurbiprofen	Fenoprofen 400mg
Ibuprofen	Ibuprofen/Famotidine
Indocin	Ketorolac Tromethamine Nasal Spray
Indomethacin	Ketoprofen
Ketoprofen ER	Licart Patch
Ketorolac	Meloxicam Cap
Meclofenamate	Naproxen CR, DR, ER, EC
Mefenamic Acid	Naproxen/Esomeprazole
Meloxicam Tab	Pennsaid <sup>BvG</sup>
Nabumetone	Qmiiz ODT
Naproxen IR	Relafen DS
Naproxen Susp <sup>AR</sup>	Zipsor <sup>BvG</sup>
Oxaprozin	Zorvolex
Piroxicam	
Sulindac	

[Link to Criteria: Analgesic Agents: NSAIDs](#)

Analgesic Agents: Opioids	
PREFERRED	NON-PREFERRED
Acetaminophen/Codeine <sup>QL</sup>	Acetaminophen/Caffeine/Dihydrocodeine <sup>QL</sup>
Butalbital/Acetaminophen/Caffeine/Codeine <sup>QL</sup>	Belbuca <sup>QL</sup>
Butalbital/Aspirin/Caffeine/Codeine <sup>QL</sup>	Benzhydrocodone/Acetaminophen <sup>QL</sup>
Butorphanol <sup>QL</sup>	Buprenorphine TD Patch Weekly <sup>QL</sup>
Butrans <sup>BvG PA QL</sup>	Butalbital/Acetaminophen/Caffeine/Codeine 50/300/40/30mg <sup>QL</sup>
Codeine <sup>QL</sup>	Dsuvia <sup>QL</sup>
Hydrocodone/Acetaminophen <sup>QL</sup>	Fentanyl <sup>QL</sup>
Hydromorphone IR <sup>QL</sup>	Hydrocodone Bitartrate ER 12HR Cap <sup>QL</sup>
Morphine ER Tab <sup>PA QL</sup>	Hydrocodone Bitartrate ER 24HR Tab <sup>QL</sup>
Morphine IR Tab, Sol <sup>QL</sup>	Hydrocodone/Acetaminophen 5-300, 7.5-300, 10-300mg <sup>QL</sup>
Nucynta IR, ER <sup>QL</sup>	Hydrocodone/Ibuprofen <sup>QL</sup>
Oxycodone Cap, Sol, Tab <sup>QL</sup>	Hydromorphone ER <sup>QL</sup>
Oxycodone/Acetaminophen <sup>QL</sup>	Levorphanol <sup>QL</sup>
Tramadol <sup>QL</sup>	Meperidine <sup>QL</sup>
Tramadol/Acetaminophen <sup>QL</sup>	Methadone <sup>QL</sup>
	Morphine ER 24HR Cap <sup>QL</sup>

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Analgesic Agents: Opioids	
PREFERRED	NON-PREFERRED
	Nucynta, ER <sup>QL</sup> Oxaydo <sup>QL</sup> Oxycodone ER <sup>QL</sup> Oxycodone/Ibuprofen <sup>QL</sup> Oxymorphone IR, ER <sup>QL</sup> Pentazocine/Naloxone <sup>QL</sup> Seglents <sup>QL</sup> Tramadol ER, Sol <sup>QL</sup> Xtampza ER <sup>QL</sup>

[Link to Criteria: Analgesic Agents: Opioids](#)

Blood Formation, Coagulation, and Thrombosis Agents: Colony Stimulating Factors	
PREFERRED	NON-PREFERRED
Neupogen <sup>PA</sup> Nivestym <sup>PA</sup> Releuko <sup>PA</sup> Ziextenzo <sup>PA</sup>	Fulphila Granix Leukine Neulasta Nivestym Nyvepria Releuko Udenyca Zarxio Ziextenzo

[Link to Criteria: Blood Formation, Coagulation, and Thrombosis Agents: Colony Stimulating Factors](#)

Blood Formation, Coagulation, and Thrombosis Agents: Hematopoietic Agents	
PREFERRED	NON-PREFERRED
Epogen <sup>PA</sup> Mircera <sup>PA</sup> Retacrit <sup>PA</sup>	Aranesp Procrit

[Link to Criteria: Blood Agents: Blood Formation, Coagulation, And Thrombosis Agents: Hematopoietic Agents](#)

Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia Factor*	
PREFERRED	NON-PREFERRED
Advate <sup>PA</sup> Adynovate <sup>PA</sup> Afstyla <sup>PA</sup> Alphanate <sup>PA</sup> Alphanine SD <sup>PA</sup> Alprolix <sup>PA</sup> Benefix <sup>PA</sup> Corifact <sup>PA</sup> Eloctate <sup>PA</sup> Esperoct <sup>PA</sup> Feiba <sup>PA</sup> Hemlibra <sup>PA</sup> Hemofil M <sup>PA</sup> Humate-P <sup>PA</sup>	Jivi Kovaltry Nuwiq Obizur Rebinyn Sevenfact Vonvendi

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Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia Factor*	
PREFERRED	NON-PREFERRED
Idelvion <sup>PA</sup>	
Ixinity <sup>PA</sup>	
Koate <sup>PA</sup>	
Kogenate FS <sup>PA</sup>	
Mononine <sup>PA</sup>	
Novoeight <sup>PA</sup>	
Novoseven RT <sup>PA</sup>	
Profilnine <sup>PA</sup>	
Recombinate <sup>PA</sup>	
Rixubis <sup>PA</sup>	
Wilate <sup>PA</sup>	
Xyntha <sup>PA</sup>	

[Link to Criteria: Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia Factors](#)

Blood Formation, Coagulation, and Thrombosis Agents: Heparin-Related Preparations	
PREFERRED	NON-PREFERRED
Enoxaparin	Fondaparinux
	Fragmin

[Link to Criteria: Blood Formation, Coagulation, and Thrombosis Agents: Heparin-Related Preparations](#)

Blood Formation, Coagulation, and Thrombosis Agents: Oral Anticoagulants	
PREFERRED	NON-PREFERRED
Eliquis	Dabigatran
Pradaxa <sup>BvG</sup>	Savaysa
Warfarin	
Xarelto <sup>QL</sup>	

[Link to Criteria: Blood Formation, Coagulation, and Thrombosis Agents: Oral Anticoagulants](#)

Blood Formation, Coagulation, and Thrombosis Agents: Oral Antiplatelet	
PREFERRED	NON-PREFERRED
Aspirin	Yosprala
Aspirin/Dipyridamole ER	Zontivity
Brilinta	
Clopidogrel	
Prasugrel <sup>QL</sup>	

[Link to Criteria: Blood Formation, Coagulation, and Thrombosis Agents: Oral Antiplatelet](#)

Cardiovascular Agents: Angina, Hypertension and Heart Failure	
PREFERRED	NON-PREFERRED
Acebutolol <sup>QL</sup>	Aliskiren
Amlodipine <sup>QL</sup>	Aspruzo Sprinkle
Amlodipine/Benazepril	Camzyos
Amlodipine/Olmesartan <sup>QL</sup>	Candesartan
Amlodipine/Valsartan	Candesartan/HCTZ
Amlodipine/Valsartan/HCTZ	Carospir
Atenolol <sup>QL</sup>	Carvedilol ER
Atenolol/Chlorthalidone	Corlanor
Benazepril	Edarbi
Benazepril/HCTZ	Diltiazem 24HR ER Tabs <sup>QL</sup>

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# Cardiovascular Agents: Angina, Hypertension and Heart Failure

PREFERRED	NON-PREFERRED
Betaxolol <sup>QL</sup>	Edarbyclor
Bisoprolol <sup>QL</sup>	Enalapril Sol
Bisoprolol/HCTZ	Hydralazine/HCTZ
Bystolic <sup>BvG</sup>	Innopran XL
Captopril	Isradipine
Captopril/HCTZ	Kaspargo
Cartia XT	Katerzia
Carvedilol <sup>QL</sup>	Kerendia
Clonidine	Nebivolol
Diltiazem <sup>QL</sup>	Nimodipine
Diltiazem 12HR ER Cap <sup>QL</sup>	Nisoldipine
Diltiazem 24HR ER Cap <sup>QL</sup>	Norliqva
Doxazosin	Nymalize
Dutoprol	Qbrelis
Enalapril Tab	Sotylize <sup>AR</sup>
Enalapril/HCTZ	Tekturna/HCTZ
Entresto <sup>PA</sup>	Telmisartan
Epaned <sup>BvG</sup> Enalapril Sol	Telmisartan/HCTZ
Eplerenone	Verapamil 200, 300mg ER 24HR <sup>QL</sup>
Felodipine ER <sup>QL</sup>	Verquvo
Fosinopril	
Fosinopril/HCTZ	
Guanfacine	
Hemangeol <sup>AR-PA</sup>	
Hydralazine	
Irbesartan <sup>QL</sup>	
Irbesartan/HCTZ <sup>QL</sup>	
Labetalol <sup>QL</sup>	
Lisinopril	
Lisinopril/HCTZ	
Losartan <sup>QL</sup>	
Losartan/HCTZ	
Olmesartan	
Olmesartan/Amlodipine/HCTZ	
Olmesartan/HCTZ	
Methyldopa	
Methyldopa/HCTZ	
Metoprolol Succinate <sup>QL</sup>	
Metoprolol Tartrate <sup>QL</sup>	
Metoprolol/HCTZ <sup>QL</sup>	
Minoxidil	
Moexipril	
Nadolol <sup>QL</sup>	
Nadolol/Bendroflumethiazide	
Nicardipine <sup>QL</sup>	
Nifedipine <sup>QL</sup>	
Perindopril	
Pindolol <sup>QL</sup>	

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## Cardiovascular Agents: Angina, Hypertension and Heart Failure

PREFERRED	NON-PREFERRED
Prazosin	
Propranolol	
Propranolol/HCTZ	
Quinapril	
Quinapril/HCTZ	
Ramipril	
Ranolazine	
Sotalol <sup>QL</sup>	
Spironolactone	
Spironolactone/HCTZ	
Telmisartan/Amlodipine	
Terazosin	
Timolol <sup>QL</sup>	
Trandolapril	
Trandolapril/Verapamil	
Valsartan <sup>QL</sup>	
Valsartan/HCTZ <sup>QL</sup>	
Verapamil IR, SR <sup>QL</sup>	

[Link to Criteria: Cardiovascular Agents: Angina, Hypertension & Heart Failure](#)

## Cardiovascular Agents: Antiarrhythmics

PREFERRED	NON-PREFERRED
Amiodarone 200mg <sup>QL</sup>	Amiodarone 100, 400mg <sup>QL</sup>
Disopyramide <sup>QL</sup>	Multaq
Dofetilide	
Flecainide <sup>QL</sup>	
Mexiletine <sup>QL</sup>	
Norpace CR	
Propafenone IR, ER <sup>QL</sup>	
Quinidine IR, ER <sup>QL</sup>	

[Link to Criteria: Cardiovascular Agents: Antiarrhythmics](#)

## Cardiovascular Agents: Lipotropics

PREFERRED	NON-PREFERRED
Atorvastatin <sup>QL</sup>	Altoprev
Cholestyramine Regular, Light	Amlodipine/Atorvastatin
Colestipol Tab	Colesevelam
Ezetimibe	Colestipol Granules
Fenofibrate 48, 145mg Tab <sup>QL</sup>	Ezetimibe/Simvastatin
Gemfibrozil <sup>QL</sup>	Ezallor
Lovastatin <sup>QL</sup>	Fenofibrate Cap <sup>QL</sup>
Omega-3-Acid Ethyl Esters	Fenofibrate 40, 54, 120, 160mg Tab <sup>QL</sup>
Niacin IR, ER OTC <sup>QL</sup>	Fenofibric Acid <sup>QL</sup>
Praluent <sup>PA</sup>	Fluvastatin
Pravastatin	Juxtapid
Prevalite	Livalo
Repatha <sup>PA</sup>	Nexletol
Rosuvastatin <sup>QL</sup>	Nexlizet
Simvastatin <sup>QL</sup>	Niacin ER Tab <sup>QL</sup>

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Cardiovascular Agents: Lipotropics	
PREFERRED	NON-PREFERRED
	Vascepa Zypitamag

[Link to Criteria: Cardiovascular Agents: Lipotropics](#)

Cardiovascular Agents: Pulmonary Arterial Hypertension*	
PREFERRED	NON-PREFERRED
Ambrisentan <sup>PA</sup> Sildenafil <sup>PA</sup> Sildenafil Susp <sup>AR PA</sup> Tadalafil <sup>PA</sup> Tracleer Tab <sup>BvG PA</sup>	Adempas Bosentan Epoprostenol Opsumit Tracleer Susp Treprostinil Tyvaso Uptravi Ventavis

[Link to Criteria: Cardiovascular Agents: Pulmonary Arterial Hypertension](#)

Central Nervous System (CNS) Agents: Alzheimer's Agents*	
PREFERRED	NON-PREFERRED
Donepezil 5, 10mg Tab <sup>AR QL</sup> Donepezil ODT <sup>AR QL</sup> Exelon Patch <sup>AR BvG</sup> Galantamine IR Tab, ER Cap <sup>AR QL</sup> Memantine Tab <sup>AR</sup> Rivastigmine Cap <sup>AR</sup>	Adlarity <sup>AR</sup> Donepezil 23mg Tab <sup>AR QL</sup> Galantamine Sol <sup>AR QL</sup> Memantine ER, Sol <sup>AR</sup> Namzaric Rivastigmine Patch <sup>AR</sup>

[Link to Criteria: Central Nervous System \(CNS\) Agents: Alzheimer's Agents](#)

Central Nervous System (CNS) Agents: Anti-Migraine Agents, Acute	
PREFERRED	NON-PREFERRED
Imitrex Nasal Spray <sup>BvG</sup> Naratriptan <sup>QL</sup> Nurtec ODT <sup>QL ST</sup> Rizatriptan <sup>QL</sup> Sumatriptan <sup>QL</sup> Tosymra <sup>QL</sup>	Almotriptan Dihydroergotamine Eletriptan Ergomar Frovatriptan Migergot Onzetra Xsail <sup>QL</sup> Reyvow Sumatriptan/Naproxen Sumatriptan Nasal Spray <sup>QL</sup> Tosymra <sup>QL</sup> Trudhesa Ubrelyv Zolmitriptan

[Link to Criteria: Central Nervous System \(CNS\) Agents: Anti-Migraine Agents, Acute](#)

Central Nervous System (CNS) Agents: Anti-Migraine Agents, Cluster Headache	
PREFERRED	NON-PREFERRED
Verapamil	Emgality

[Link to Criteria: Central Nervous System \(CNS\) Agents: Anti-Migraine Agents, Cluster Headache](#)

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Central Nervous System (CNS) Agents: Anti-Migraine Agents, Prophylaxis	
PREFERRED	NON-PREFERRED
Aimovig <sup>QL ST</sup>	Emgality <sup>QL</sup>
Ajovy <sup>QL ST</sup>	Nurtec ODT <sup>QL</sup>
Cardiovascular Agents: Beta-Blockers	Qulipta <sup>QL</sup>
CNS Agents: Anticonvulsants	
CNS Agents: Serotonin-Norepinephrine Reuptake Inhibitors	
CNS Agents: Tricyclic Antidepressants	

[Link to Criteria: Central Nervous System \(CNS\) Agents: Anti-Migraine Agents, Prophylaxis](#)

Central Nervous System (CNS) Agents: Anticonvulsants*	
PREFERRED	NON-PREFERRED
Banzel Tab <sup>BvG</sup>	Aptiom
Carbamazepine	Briviact
Clobazam	Celontin
Clonazepam	Clonazepam ODT
Diacomit <sup>PA QL</sup>	Elepsia XR
Divalproex IR, ER	Felbamate
Epidiolex <sup>PA ST QL</sup>	Fintepla
Eprontia <sup>AR</sup>	Lacosamide
Ethosuximide	Lamotrigine ER, ODT
Fycompa <sup>ST</sup>	Levetiracetam ER Tab
Gabapentin <sup>QL</sup>	Oxtellar XR
Lamictal ODT <sup>BvG</sup>	Peganone
Lamotrigine	Rufinamide Tab, Soln
Levetiracetam IR Tab, Sol	Spritam
Oxcarbazepine Tab	Sympazan
Phenobarbital	Tiagabine
Phenytoin	Topiramate ER Sprinkle Cap Qudexy XR <sup>BvG</sup>
Pregabalin <sup>QL</sup>	Topiramate Sprinkle Cap
Primidone	Trokendi XR
Topiramate	Vigabatrin
Trileptal Susp <sup>BvG</sup>	Vigabatrin Powder <sup>AR</sup>
Valproic Acid	Xcopri
Vimpat <sup>BvG</sup> Lacosamide <sup>ST</sup>	
Zonisamide	

[Link to Criteria: Central Nervous System \(CNS\) Agents: Anticonvulsants](#)

Central Nervous System (CNS) Agents: Anticonvulsants Rescue	
PREFERRED	NON-PREFERRED
Diastat	
Diazepam Gel	
Nayzilam <sup>AR</sup>	
Valtoco <sup>AR</sup>	

[Link to Criteria: Central Nervous System \(CNS\) Agents: Anticonvulsants Rescue](#)

Central Nervous System (CNS) Agents: Antidepressants*	
PREFERRED	NON-PREFERRED
Bupropion <sup>QL</sup>	Aplenzin
Bupropion SR (generic of Wellbutrin SR) <sup>QL</sup>	Brisdelle
Bupropion XL (generic of Wellbutrin XL) <sup>QL</sup>	Bupropion XL (generic of Forfivo XL) <sup>QL</sup>

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### Central Nervous System (CNS) Agents: Antidepressants\*

PREFERRED	NON-PREFERRED
Citalopram <sup>QL</sup>	Clomipramine
Duloxetine 20, 30, 60mg <sup>QL</sup>	Desvenlafaxine
Escitalopram <sup>QL</sup>	Drizalma Sprinkle
Fluoxetine 10, 20, 40mg <sup>QL</sup>	Duloxetine 40mg <sup>QL</sup>
Fluoxetine Sol <sup>QL</sup>	Emsam
Fluvoxamine <sup>QL</sup>	Fetzima
Mirtazapine <sup>QL</sup>	Fluoxetine 60mg, DR <sup>QL</sup>
Nefazodone <sup>QL</sup>	Fluvoxamine ER <sup>QL</sup>
Paroxetine IR Tab, Sol <sup>QL</sup>	Marplan
Sertraline	Paroxetine Cap, ER Tab
Tranylcypromine	Pexeva
Trazodone 50, 100, 150mg <sup>QL</sup>	Phenelzine
Venlafaxine IR Tab, ER Cap <sup>QL</sup>	Trazodone 300mg <sup>QL</sup>
	Trintellix
	Venlafaxine ER Tab
	Viibryd <sup>BvG</sup>

[Link to Criteria: Central Nervous System \(CNS\) Agents: Antidepressants](#)

### Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents

PREFERRED	NON-PREFERRED
Amphetamine/Dextroamphetamine IR, ER <sup>AR QL</sup>	Adhansia XR <sup>AR</sup>
Atomoxetine Cap <sup>AR QL</sup>	Adzenys ER, XR ODT
Clonidine ER	Amphetamine Tab
Concerta <sup>AR QL</sup>	Azstarys <sup>AR</sup>
Dexmethylphenidate Tab <sup>AR QL</sup>	Cotempla XR ODT <sup>AR</sup>
Dexmethylphenidate ER (generic of Focalin XR) <sup>AR QL</sup>	Daytrana <sup>AR BvG</sup>
Dextroamphetamine IR Tab, ER Cap <sup>AR QL</sup>	<del>Dyanavel XR</del>
Dextroamphetamine Sol <sup>AR</sup>	Evekeo ODT
<del>Dyanavel XR</del> <sup>AR</sup>	Jornay PM <sup>AR</sup>
<del>Focalin XR</del>	Methamphetamine
Guanfacine ER <sup>QL</sup>	Methylphenidate Chewable Tab <sup>AR QL</sup>
Methylphenidate ER Cap <sup>AR QL</sup> (generic of Metadate CD, Ritalin LA)	Methylphenidate ER <sup>AR QL</sup> (generic of Aptensio XR, Relexxii)
Methylphenidate ER Tab <sup>AR QL</sup> (generic of Concerta, Methylin ER, Ritalin SR)	Mydayis <sup>AR QL</sup>
Methylphenidate Sol <sup>AR QL</sup>	Vyvanse Chewable Tab
Methylphenidate Tab <sup>AR QL</sup>	Zenzedi <sup>AR QL</sup>
<del>Procentra</del> <sup>AR</sup>	
Qelbree <sup>ST</sup>	
Quillichew ER <sup>AR</sup>	
Quillivant XR <sup>AR</sup>	
Ritalin LA <sup>AR QL</sup>	
Vyvanse Cap <sup>QL</sup>	

[Link to Criteria: Central Nervous System \(CNS\) Agents: Attention Deficit Hyperactivity Disorder Agents](#)

### Central Nervous System (CNS) Agents: Atypical Antipsychotics\*

PREFERRED	NON-PREFERRED
Abilify Maintena <sup>QL</sup>	Abilify Mycite
Aripiprazole <sup>QL</sup>	Aripiprazole Sol

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### Central Nervous System (CNS) Agents: Atypical Antipsychotics\*

PREFERRED	NON-PREFERRED
Aristada <sup>QL</sup>	Asenapine
Aristada Initio	Caplyta
Clozapine	Clozapine ODT Rapdis
Fanapt <sup>ST</sup>	Fluoxetine/Olanzapine
Geodon <sup>QL</sup>	Lybalvi
Invega Tab <sup>BvG</sup>	Nuplazid
Invega Hafyera ER <sup>PA</sup>	Olanzapine ODT
Invega Sustenna <sup>QL</sup>	Paliperidone
Invega Trinza <sup>QL</sup>	Rexulti
Latuda <sup>ST QL</sup>	Secuado
Olanzapine <sup>QL</sup>	Versacloz
Perseris	Vraylar
Quetiapine IR, ER <sup>QL</sup>	Zyprexa Relprevv <sup>QL</sup>
<del>Risperdal</del>	
Risperdal Consta <sup>QL</sup>	
Risperidone <sup>QL</sup>	
Saphris <sup>BvG ST</sup>	
Ziprasidone <sup>QL</sup>	

[Link to Criteria: Central Nervous System \(CNS\) Agents: Atypical Antipsychotics](#)

### Central Nervous System (CNS) Agents: Fibromyalgia Agents

PREFERRED	NON-PREFERRED
Pregabalin <sup>QL</sup>	Savella

[Link to Criteria: Central Nervous System \(CNS\) Agents: Fibromyalgia Agents](#)

### Central Nervous System (CNS) Agents: Medication Assisted Treatment of Opioid Addiction

PREFERRED	NON-PREFERRED
Buprenorphine/Naloxone	Buprenorphine
Clonidine	Lucemyra <sup>QL</sup>
Sublocade <sup>QL</sup>	
Suboxone	
Vivitrol	
Zubsolv	

[Link to Criteria: Central Nervous System \(CNS\) Agents: Medication Assisted Treatment of Opioid Addiction](#)

### Central Nervous System (CNS) Agents: Movement Disorders

PREFERRED	NON-PREFERRED
Austedo <sup>PA ST QL</sup>	
Ingrezza <sup>PA</sup>	
Tetrabenazine <sup>PA</sup>	

[Link to Criteria: Central Nervous System \(CNS\) Agents: Movement Disorders](#)

### Central Nervous System (CNS) Agents: Multiple Sclerosis\*

PREFERRED	NON-PREFERRED
Aubagio	Bafiertam
Avonex	Extavia
Betaseron	Glatiramer
Copaxone <sup>BvG</sup>	Glatopa
Dalfampridine	Kesimpta

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Central Nervous System (CNS) Agents: Multiple Sclerosis*	
PREFERRED	NON-PREFERRED
Dimethyl Fumarate	Mavenclad
Gilenya	Mayzent <sup>QL</sup>
Rebif	Plegridy
	Ponvory
	Vumerity
	Zeposia

[Link to Criteria: Central Nervous System \(CNS\) Agents: Multiple Sclerosis](#)

Central Nervous System (CNS) Agents: Narcolepsy	
PREFERRED	NON-PREFERRED
Amphetamine/Dextroamphetamine IR/ER <sup>AR</sup>	Sunosi
Armodafinil	Wakix
Dextroamphetamine ER <sup>AR</sup>	Xyrem
Methylphenidate ER <sup>AR</sup>	Xywav
Methylphenidate Tab <sup>AR</sup>	
Modafinil	

[Link to Criteria: Central Nervous System \(CNS\) Agents: Narcolepsy](#)

Central Nervous System (CNS) Agents: Neuropathic Pain	
PREFERRED	NON-PREFERRED
Amitriptyline	Gralise
Carbamazepine	Horizant
Desipramine	Pregabalin ER
Doxepin 10, 25, 50, 75, 100, 150mg	Ztlido
Doxepin Sol	
Duloxetine	
Gabapentin <sup>QL</sup>	
Imipramine	
Lidocaine Patch	
Nortriptyline	
Oxcarbazepine	
Pregabalin <sup>QL</sup>	

[Link to Criteria: Central Nervous System \(CNS\) Agents: Neuropathic Pain](#)

Central Nervous System (CNS) Agents: Parkinson's Agents	
PREFERRED	NON-PREFERRED
Amantadine	Apokyn
Carbidopa	Carbidopa/Levodopa Dispersible Tab
Carbidopa/Levodopa	Carbidopa/Levodopa/Entacapone
Entacapone	Gocovri
Pramipexole	Inbrija
Ropinirole	Kynmobi
Selegiline	Neupro
	Nourianz
	Ongentys
	Osmolex ER
	Pramipexole ER
	Rasagiline
	Ropinirole ER

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Central Nervous System (CNS) Agents: Parkinson's Agents	
PREFERRED	NON-PREFERRED
	Rytary Tolcapone Xadago Zelapar

[Link to Criteria: Central Nervous System \(CNS\) Agents: Parkinson's Agents](#)

Central Nervous System (CNS) Agents: Restless Legs Syndrome	
PREFERRED	NON-PREFERRED
Pramipexole Ropinirole	Horizant Neupro

[Link to Criteria: Central Nervous System \(CNS\) Agents: Restless Legs Syndrome](#)

Central Nervous System (CNS) Agents: Sedative-Hypnotics, Non-Barbiturate	
PREFERRED	NON-PREFERRED
Estazolam <sup>QL</sup> Temazepam 15, 30mg <sup>QL</sup> Zaleplon <sup>QL</sup> Zolpidem <sup>QL</sup>	Belsomra Dayvigo Doxepin 3, 6mg Eszopiclone <sup>QL</sup> Intermezzo Quviviq Ramelteon Temazepam 7.5, 22mg <sup>QL</sup> Zolpidem ER, SL

[Link to Criteria: Central Nervous System \(CNS\) Agents: Sedative-Hypnotics, Non-Barbiturate](#)

Central Nervous System (CNS) Agents: Skeletal Muscle Relaxants, Non-Benzodiazepine	
PREFERRED	NON-PREFERRED
Baclofen Tab Chlorzoxazone 250, 500mg <sup>QL</sup> Cyclobenzaprine 5, 10mg <sup>QL</sup> Dantrolene Methocarbamol <sup>QL</sup> Tizanidine Tab <sup>QL</sup>	Baclofen Solution Carisoprodol Chlorzoxazone 375, 750mg Cyclobenzaprine 7.5mg Cyclobenzaprine ER <sup>QL</sup> Fleqsuvy Lyvispah Metaxalone Orphenadrine Tizanidine Cap

[Link to Criteria: Central Nervous System \(CNS\) Agents: Skeletal Muscle Relaxants, Non-Benzodiazepine](#)

Central Nervous System (CNS) Agents: Smoking Deterrents	
PREFERRED	NON-PREFERRED
Nicotine <sup>QL</sup> Bupropion <sup>QL</sup> Chantix <sup>QL</sup> Varenicline <sup>QL</sup>	

[Link to Criteria: Central Nervous System \(CNS\) Agents: Smoking Deterrents](#)

### Dermatologic Agents: Oral Acne Products

PREFERRED	NON-PREFERRED
Accutane <sup>PA</sup>	Absorica
Amnesteem <sup>PA</sup>	Absorica LD
Claravis <sup>PA</sup>	
Isotretinoin <sup>PA</sup>	
Myorisan <sup>PA</sup>	
Zenatane <sup>PA</sup>	

[Link to Criteria: Dermatologic Agents: Oral Acne Products](#)

### Dermatologic Agents: Topical Acne Products

PREFERRED	NON-PREFERRED
Adapalene Gel 0.1% <sup>AR</sup>	Adapalene Cream, Sol 0.1% <sup>AR</sup>
Azelex Cream	Adapalene Gel 0.3% <sup>AR</sup>
Benzoyl Peroxide	Adapalene/Benzoyl Peroxide <sup>AR</sup>
Clindamycin Gel, Lot, Sol	Aklief <sup>AR</sup>
Clindamycin/Benzoyl Peroxide	Altreno <sup>AR</sup>
Erythromycin	Amzeeq
Erythromycin/Benzoyl Peroxide	Arazlo <sup>AR</sup>
Neuac	Azelaic Acid Gel
Sodium Sulfacetamide	Benzoyl Peroxide Foam
Sodium Sulfacetamide/Sulfur Cream	Clindacin Kit
Sodium Sulfacetamide/Sulfur Wash Susp	Clindamycin Foam, Swabs
Tretinoin <sup>AR</sup>	Clindamycin/Tretinoin <sup>AR</sup>
	Dapsone Gel
	Epsolay
	Finacea Foam
	Onexton Gel
	Ovace Plus
	Plixda <sup>AR</sup>
	Sodium Sulfacetamide/Sulfur Gel
	Sodium Sulfacetamide Pads
	Tazarotene Cream, Foam 0.1% <sup>AR</sup>
	Twynco <sup>AR</sup>
	Winlevi

[Link to Criteria: Dermatologic Agents: Topical Acne Products](#)

### Endocrine Agents: Androgens

PREFERRED	NON-PREFERRED
Androderm <sup>AR PA</sup>	Jatenzo <sup>AR</sup>
Testosterone Gel 1% <sup>AR PA</sup>	Methyltestosterone <sup>AR</sup>
Testosterone Gel 1% Pump <sup>AR PA</sup>	Natesto <sup>AR</sup>
	Testopel <sup>AR</sup>
	Testosterone Cypionate <sup>AR</sup>
	Testosterone Gel 1.62%, 2% <sup>AR</sup>
	Testosterone Sol 30mg/ACT <sup>AR</sup>
	Tlando <sup>AR</sup>
	Xyosted <sup>AR</sup>

[Link to Criteria: Endocrine Agents: Androgens](#)

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### Endocrine Agents: Diabetes – Hypoglycemia Treatments

PREFERRED	NON-PREFERRED
Baqsimi <sup>QL</sup>	Glucagon Emerg Kit [Labeler 00548 & 63323] <sup>QL</sup>
Glucagen Hypokit <sup>QL</sup>	
Glucagon Emerg Kit [Labeler 00002] <sup>QL</sup>	
Gvoke <sup>QL</sup>	
Zegalogue <sup>QL</sup>	

[Link to Criteria: Endocrine Agents: Diabetes – Hypoglycemia Treatments](#)

### Endocrine Agents: Diabetes – Insulin

PREFERRED	NON-PREFERRED
Apidra	Admelog <sup>QL</sup>
Humalog 50-50	Afrezza
Humalog 75-25	Basaglar <sup>QL</sup>
Humalog U-100 <sup>QL</sup>	Fiasp <sup>QL</sup>
Humulin 70-30	Humalog U-200 <sup>QL</sup>
Humulin R U-500 <sup>QL</sup>	Humulin N U-100
Insulin Aspart <sup>QL</sup>	Humulin R U-100
Insulin Aspart Protamine/Insulin Aspart	Insulin glargine
Insulin Lispro <sup>QL</sup>	Lyumjev
Lantus <sup>BvG QL</sup>	Novolin 70-30
Levemir	Novolin N U-100
Novolog 70-30	Novolin R U-100
Novolog U-100 <sup>QL</sup>	
Toujeo	
Tresiba <sup>ST</sup>	

[Link to Criteria: Endocrine Agents: Diabetes – Insulin](#)

### Endocrine Agents: Diabetes – Non-Insulin

PREFERRED	NON-PREFERRED
Acarbose <sup>QL</sup>	Adlyxin
Actoplus Met XR	Alogliptin
Byetta	Alogliptin/Metformin
Farxiga	Bydureon Bcise
Glimepiride <sup>QL</sup>	Glimepiride/Pioglitazone
Glipizide <sup>QL</sup>	Glucophage
Glipizide/Metformin <sup>QL</sup>	Glyxambi
Glyburide <sup>QL</sup>	Invokamet XR
Glyburide/Metformin <sup>QL</sup>	Jentadueto XR
Invokamet	Kombiglyze XR
Invokana	Metformin ER <sup>QL</sup> (Generic of Fortamet)
Janumet	Metformin Sol
Janumet XR	<b>Mounjaro</b>
Januvia	Onglyza
Jardiance	Ozempic
Jentadueto	Pioglitazone/Alogliptin
Metformin IR, ER <sup>QL</sup> (Generic of Glucophage XR)	Qtern
Miglitol	Rybelsus
Nateglinide <sup>QL</sup>	Segluromet
Pioglitazone <sup>QL</sup>	Soliqua
Pioglitazone/Metformin <sup>QL</sup>	Steglatro

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Endocrine Agents: Diabetes – Non-Insulin	
PREFERRED	NON-PREFERRED
Repaglinide	Steglujan
Repaglinide/Metformin	Symlinpen
Synjardy	Synjardy XR
Tradjenta	Trijardy XR
Trulicity <sup>QL</sup>	Xigduo XR
Victoza <sup>QL</sup>	Xultophy

[Link to Criteria: Endocrine Agents: Diabetes – Non-Insulin](#)

Endocrine Agents: Endometriosis	
PREFERRED	NON-PREFERRED
Danazol <sup>ST</sup>	Synarel
Depo-Subq Provera 104 <sup>ST</sup>	
Lupaneta Pack <sup>ST</sup>	
Lupron Depot <sup>ST QL</sup> 3.75, 11.25mg	
Myfembree <sup>ST QL</sup>	
Orilissa <sup>ST</sup>	
Zoladex <sup>ST</sup>	

[Link to Criteria: Endocrine Agents: Endometriosis](#)

Endocrine Agents: Estrogenic Agents	
PREFERRED	NON-PREFERRED
Climara Pro <sup>QL</sup>	Angeliq
Combipatch <sup>QL</sup>	Climara <sup>QL</sup>
Dotti <sup>QL</sup>	Divigel
Estradiol Cream, Tab	Duavee
Estradiol Patch <sup>QL</sup>	Estradiol 10mcg Vag Tab
Lyllana <sup>QL</sup>	Estradiol/Norethindrone Acetate
Estring <sup>QL</sup>	Evamist
Ethinyl Estradiol/Norethindrone Acetate	Femring
Menest	Menostar <sup>QL</sup>
Premarin	Minivelle <sup>QL</sup>
Premphase	Prefest
Prempro	Vivelle-Dot <sup>QL</sup>

[Link to Criteria: Endocrine Agents: Estrogenic Agents](#)

Endocrine Agents: Growth Hormone	
PREFERRED	NON-PREFERRED
Genotropin <sup>PA</sup>	Genotropin
Norditropin <sup>PA</sup>	Humatrope
Omnitrope <sup>PA</sup>	Nutropin
	Omnitrope
	Saizen
	Serostim
	Skytrofa
	Zomacton

[Link to Criteria: Endocrine Agents: Growth Hormone](#)

### Endocrine Agents: Osteoporosis – Bone Ossification Enhancers

PREFERRED	NON-PREFERRED
Alendronate Tab	Alendronate Susp
Calcitonin-Salmon	Fosamax Plus D
Forteo <sup>QL</sup>	Risedronate
Ibandronate	Tymlos <sup>QL</sup>

[Link to Criteria: Endocrine Agents: Osteoporosis – Bone Ossification Enhancers](#)

### Endocrine Agents: Progestin Agents

PREFERRED	NON-PREFERRED
Hydroxyprogesterone Caproate <sup>QL</sup>	
Makena <sup>QL</sup>	
Medroxyprogesterone Acetate Tab	
Megestrol	
Norethindrone Acetate	
Progesterone	
Progesterone In Oil	

[Link to Criteria: Endocrine Agents: Progestin Agents](#)

### Endocrine Agents: Uterine Fibroids

PREFERRED	NON-PREFERRED
Lupron Depot <sup>PA</sup> 3.75, 11.25mg	Myfembree <sup>QL</sup>
Myfembree <sup>QL</sup>	Oriahnn <sup>QL</sup>
Oriahnn <sup>PA-QL</sup>	

[Link to Criteria: Endocrine Agents: Uterine Fibroids](#)

### Gastrointestinal Agents: Anti-Emetics

PREFERRED	NON-PREFERRED
Aprepitant 40, 125mg	Aprepitant 80 mg
Diclegis <sup>BvG</sup>	Aprepitant TriPac
Dimenhydrinate	Bonjesta
Diphenhydramine	Doxylamine/Pyridoxine
Emend 125mg Susp	Metoclopramide ODT
Emend 80mg <sup>BvG</sup>	Sancuso
Emend TriPac <sup>BvG</sup>	Zuplenz
Meclizine	
Metoclopramide	
Ondansetron	
Phosphorated Carbohydrate	
Prochlorperazine	
Promethazine	
Scopolamine	
Trimethobenzamide	

[Link to Criteria: Gastrointestinal Agents: Anti-Emetics](#)

### Gastrointestinal Agents: Crohn's Disease

PREFERRED	NON-PREFERRED
Azathioprine	Ortikos ER
Budesonide ER Cap	
Mercaptopurine	
Methotrexate	

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### Gastrointestinal Agents: Crohn's Disease

#### PREFERRED

Sulfasalazine

#### NON-PREFERRED

[Link to Criteria: Gastrointestinal Agents: Crohn's Disease](#)

### Gastrointestinal Agents: Hepatic Encephalopathy

#### PREFERRED

Lactulose

Xifaxan<sup>ST</sup>

#### NON-PREFERRED

[Link to Criteria: Gastrointestinal Agents: Hepatic Encephalopathy](#)

### Gastrointestinal Agents: Irritable Bowel Syndrome (IBS) with Diarrhea

#### PREFERRED

Diphenoxylate/Atropine

Loperamide<sup>QL</sup>

Xifaxan<sup>ST</sup>

#### NON-PREFERRED

Alosetron

Viberzi

[Link to Criteria: Gastrointestinal Agents: Irritable Bowel Syndrome \(IBS\) with Diarrhea](#)

### Gastrointestinal Agents: Pancreatic Enzymes

#### PREFERRED

Creon

Zenpep

#### NON-PREFERRED

Pancreaze

Pertzye

Viokace

[Link to Criteria: Gastrointestinal Agents: Pancreatic Enzymes](#)

### Gastrointestinal Agents: Proton Pump Inhibitors

#### PREFERRED

Lansoprazole Cap

Nexium Granules<sup>BvG</sup>

Omeprazole Cap<sup>AR</sup>

Pantoprazole Tab<sup>AR</sup>

Protonix Pak<sup>AR BvG</sup>

#### NON-PREFERRED

Aciphex

Dexilant<sup>BvG</sup>

Esomeprazole

Esomeprazole Granules

Lansoprazole ODT

Omeprazole Tab<sup>AR</sup>

Omeprazole/Sodium Bicarbonate

Pantoprazole Packet

Prilosec Susp

Rabeprazole

[Link to Criteria: Gastrointestinal Agents: Proton Pump Inhibitors](#)

### Gastrointestinal Agents: Ulcerative Colitis

#### PREFERRED

Balsalazide Disodium

Budesonide ER Tab<sup>QL</sup>

Mesalamine DR Cap, Tab Lialda<sup>BvG</sup>

Mesalamine Enema

Mesalamine ER

Pentasa<sup>BvG</sup>

Sulfasalazine

#### NON-PREFERRED

Dipentum

Mesalamine DR Tab

Mesalamine Supp

Uceris Foam<sup>QL</sup>

Zeposia

[Link to Criteria: Gastrointestinal Agents: Ulcerative Colitis](#)

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### Gastrointestinal Agents: Unspecified GI

PREFERRED	NON-PREFERRED
Amitiza <sup>BvG ST</sup>	Aemcolo
Bisacodyl	Gattex
Casanthranol/Docusate Sodium	Ibsrela
Dicyclomine	Linness 72mcg
Diphenoxylate/Atropine	Lubiprostone
Lactulose	Motegrity
Linness <sup>ST</sup> 145, 290mcg	Mytesi
Loperamide	Relistor
Movantik <sup>ST</sup>	Symproic
Polyethylene Glycol	Trulance
Psyllium Fiber	Zorbtive
Senna	
Trulance <sup>ST</sup>	
Xifaxan <sup>ST</sup>	

[Link to Criteria: Gastrointestinal Agents: Unspecified GI](#)

### Genitourinary Agents: Benign Prostatic Hyperplasia

PREFERRED	NON-PREFERRED
Alfuzosin	Cardura XL
Doxazosin	Dutasteride/Tamsulosin
Dutasteride	Silodosin
Finasteride	
Prazosin	
Tadalafil <sup>PA</sup> 2.5, 5mg	
Tamsulosin	
Terazosin	

[Link to Criteria: Genitourinary Agents: Benign Prostatic Hyperplasia](#)

### Genitourinary Agents: Electrolyte Depleter Agents

PREFERRED	NON-PREFERRED
Calcium Acetate, Carbonate	Auryxia
Phoslyra	Lanthanum Carbonate
Sevelamer	Velphoro

[Link to Criteria: Genitourinary Agents: Electrolyte Depleter Agents](#)

### Genitourinary Agents: Urinary Antispasmodics

PREFERRED	NON-PREFERRED
Gelnique	Darifenacin <sup>QL</sup>
Myrbetriq Tab	Fesoterodine
Oxybutynin <sup>QL</sup>	Gemtesa
Oxytrol	Myrbetriq Granules <sup>AR</sup>
Solifenacin <sup>QL</sup>	Tolterodine
Toviaz <sup>BvG</sup>	Trospium <sup>QL</sup>
	Vesicare LS <sup>AR</sup>

[Link to Criteria: Genitourinary Agents: Urinary Antispasmodics](#)

AR = Age Restriction QL = Quantity Limit ST = Step Therapy Required PA = Clinical Prior Authorization Required BvG = Brand Preferred Over Generic

### Immunomodulator Agents: Systemic Inflammatory Disease

PREFERRED	NON-PREFERRED
Adbry <sup>PA</sup>	Actemra
Enbrel <sup>PA</sup>	Adbry
Dupixent <sup>PA</sup>	Cibinqo
Humira <sup>PA</sup>	Cimzia
Kineret <sup>PA</sup>	Cosentyx
Otezla <sup>PA</sup>	Dupixent
Taltz <sup>PA ST</sup>	Ilumya
Xeljanz IR <sup>PA</sup>	Kevzara
	Olumiant
	Orencia
	Rinvoq
	Siliq
	Simponi
	Skyrizi
	Stelara
	Tremfya
	Xeljanz Sol, XR

[Link to Criteria: Immunomodulator Agents for Systemic Inflammatory Disease](#)

### Infectious Disease Agents: Antibiotics – Cephalosporins

PREFERRED	NON-PREFERRED
Cefadroxil	Cephalexin 750mg
Cephalexin 250, 500mg	Cefpodoxime
Cefaclor IR, ER	Cefixime Cap
Cefaclor Susp <sup>AR</sup>	Cefixime Susp <sup>AR</sup>
Cefprozil	Suprax Chewable Tab <sup>AR</sup>
Cefprozil Susp <sup>AR</sup>	
Cefuroxime	
Cefdinir	

[Link to Criteria: Infectious Disease Agents: Antibiotics – Cephalosporins](#)

### Infectious Disease Agents: Antibiotics – Inhaled

PREFERRED	NON-PREFERRED
Arikayce <sup>PA QL</sup>	Arikayce
Tobramycin <sup>AR PA QL</sup>	Bethkis <sup>AR QL</sup>
	Cayston <sup>AR</sup>
	Kitabis Pak <sup>AR QL</sup>
	Tobi Podhaler <sup>AR QL</sup>

[Link to Criteria: Infectious Disease Agents: Antibiotics – Inhaled](#)

### Infectious Disease Agents: Antibiotics – Macrolides

PREFERRED	NON-PREFERRED
Azithromycin	Eryped
Clarithromycin	Erythrocin Stearate
	Erythromycin

[Link to Criteria: Infectious Disease Agents: Antibiotics – Macrolides](#)

AR = Age Restriction QL = Quantity Limit ST = Step Therapy Required PA = Clinical Prior Authorization Required BvG = Brand Preferred Over Generic



Infectious Disease Agents: Antibiotics – Quinolones	
PREFERRED	NON-PREFERRED
Ciprofloxacin	Baxdela
Ciprofloxacin Susp <sup>AR</sup>	Ciprofloxacin ER
Levofloxacin	Moxifloxacin
	Ofloxacin

[Link to Criteria: Infectious Disease Agents: Antibiotics – Quinolones](#)

Infectious Disease Agents: Antibiotics – Tetracyclines	
PREFERRED	NON-PREFERRED
Doxycycline 50, 100mg	<b>Demeclocycline</b>
Doxycycline Syr <sup>AR</sup>	Doxycycline 20, 40, 75, 150mg
Minocycline Cap	Doxycycline DR
Tetracycline	Minocycline IR, ER Tab
Vibramycin Susp <sup>AR</sup>	Nuzyra

[Link to Criteria: Infectious Disease Agents: Antibiotics – Tetracyclines](#)

Infectious Disease Agents: Antifungals	
PREFERRED	NON-PREFERRED
Fluconazole	Brexafemme
Flucytosine	Cresemba
Griseofulvin	Itraconazole
Ketoconazole	Noxafil Susp
Terbinafine	Oravig
	Posaconazole
	Tolsura
	Voriconazole

[Link to Criteria: Infectious Disease Agents: Antifungals](#)

Infectious Disease Agents: Antivirals – Hepatitis C Agents	
PREFERRED	NON-PREFERRED
Mavyret <sup>PA</sup>	Harvoni
Pegasys <sup>PA</sup>	Ledipasvir/Sofosbuvir
Ribavirin <sup>PA</sup>	Sovaldi
Sofosbuvir/Velpatasvir <sup>PA</sup>	Vosevi
	Zepatier

[Link to Criteria: Infectious Disease Agents: Antivirals – Hepatitis C Agents](#)

Infectious Disease Agents: Antivirals – Herpes	
PREFERRED	NON-PREFERRED
Acyclovir	Famciclovir
Valacyclovir	Sitavig

[Link to Criteria: Infectious Disease Agents: Antivirals – Herpes](#)

Infectious Disease Agents: Antivirals – HIV*	
PREFERRED	NON-PREFERRED
Abacavir Sulfate	Abacavir Susp
Abacavir/Lamivudine	Abacavir/Lamivudine/Zidovudine
Atazanavir Sulfate	Aptivus
Biktarvy	Didanosine
Cimduo	Edurant
Complera	Efavirenz/Lamivudine/Tenofovir Disoproxil Fumarate

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### Infectious Disease Agents: Antivirals – HIV\*

PREFERRED	NON-PREFERRED
Delstrigo	Emtricitabine
Descovy	Fosamprenavir
Dovato	Fuzeon
Efavirenz	Intelence <sup>BvG</sup>
Efavirenz/Emtricitabine/Tenofovir	Lamivudine Tab
Emtricitabine/Tenofovir Disoproxil Fumarate	Lamivudine Sol <sup>AR</sup>
Emtriva <sup>BvG</sup>	Lamivudine/Zidovudine
Evotaz	Lopinavir/Ritonavir
Genvoya	Nevirapine IR, ER Tab
Isentress Chew Tab <sup>AR</sup>	Nevirapine Sol <sup>AR</sup>
Isentress	Norvir Powder, Sol
Juluca	Ritonavir Tab
Kaletra Tab <sup>BvG</sup>	Selzentry <sup>BvG</sup>
Norvir Ritonavir Tab <sup>BvG</sup>	Stavudine
Odefsey	Stribild
Pifeltro	Symtuza
Prezcobix	Tybost
Prezista	Viracept
Rukobia ER <sup>PA</sup>	
Symfi <sup>BvG</sup>	
Symfi Lo <sup>BvG</sup>	
Temixys	
Tenofovir Disoproxil Fumarate 300mg	
Tivicay	
Tivicay PD	
Triumeq	
Triumeq PD <sup>PA</sup>	
Viread Tab, Powder	
Zidovudine	

[Link to Criteria: Infectious Disease Agents: Antivirals – HIV](#)

### Ophthalmic Agents: Antibiotic and Antibiotic-Steroid Combination Drops and Ointments

PREFERRED	NON-PREFERRED
Bacitracin-Polymyxin	Azasite
Ciloxan	Bacitracin
Ciprofloxacin	Besivance
Erythromycin	Blephamide
Gentamicin	Gatifloxacin
Moxifloxacin	Levofloxacin
Neomycin/Polymyxin/Bacitracin	Moxifloxacin (Generic of Moxeza)
Neomycin/Polymyxin/Bacitracin/Hydrocortisone	Neomycin/Polymyxin/Hydrocortisone
Neomycin/Polymyxin/Dexamethasone	Pred-G
Neomycin/Polymyxin/Gramicidin	Sulfacetamide Sodium Ophth Oint 10%
Ofloxacin	Tobradex ST <sup>BvG</sup>
Polymyxin/Trimethoprim	Tobramycin/Dexamethasone 0.3/0.1%
Sulfacetamide Sodium Ophth Sol 10%	Zylet
Sulfacetamide/Prednisolone	
Tobradex <sup>BvG</sup>	

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Ophthalmic Agents: Antibiotic and Antibiotic-Steroid Combination Drops and Ointments	
PREFERRED	NON-PREFERRED
Tobramycin	
Link to Criteria: Ophthalmic Agents: Antibiotic and Antibiotic-Steroid Combination Drops and Ointments	
Ophthalmic Agents: Antihistamines & Mast Cell Stabilizers	
PREFERRED	NON-PREFERRED
Azelastine	Alocril
Bepreve <sup>BvG</sup>	Alomide
Cromolyn	Bepreve <sup>BvG</sup>
Ketotifen	Epinastine
Olopatadine	Zerviate
Link to Criteria: Ophthalmic Agents: Antihistamines & Mast Cell Stabilizers	
Ophthalmic Agents: Dry Eye Treatments	
PREFERRED	NON-PREFERRED
Restasis Trays <sup>BvG ST</sup>	Cequa
	Eysuvis
	Restasis Multi-Dose
	Tyrvaya
	Xiidra
Link to Criteria: Ophthalmic Agents: Dry Eye Treatments	
Ophthalmic Agents: Glaucoma Agents	
PREFERRED	NON-PREFERRED
Alphagan P 0.1% <sup>ST</sup>	Apraclonidine
Alphagan P 0.15% <sup>BvG</sup>	Betoptic S
Azopt <sup>BvG ST</sup>	Bimatoprost
Betaxolol	Brimonidine 0.15%
Brimonidine 0.2%	Brinzolamide
Carteolol	Iopidine
Combigan <sup>BvG ST</sup>	Istalol
Dorzolamide	Lumigan
Dorzolamide/Timolol	Travoprost
Latanoprost	Vyzulta
Levobunolol	Xelpros
Metipranolol	Zioptan
Rhopressa	
Rocklatan	
Simbrinza	
Timolol	
Travatan Z <sup>BvG ST</sup>	
Link to Criteria: Ophthalmic Agents: Glaucoma Agents	
Ophthalmic Agents: NSAIDs	
PREFERRED	NON-PREFERRED
Diclofenac	Acuvail
Flurbiprofen	Bromfenac
Ketorolac	Bromsite
	Ilevro
	Nevanac

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Ophthalmic Agents: NSAIDs	
PREFERRED	NON-PREFERRED
	Prolensa

[Link to Criteria: Ophthalmic Agents: NSAIDs](#)

Ophthalmic Agents: Ophthalmic Steroids	
PREFERRED	NON-PREFERRED
Alrex <sup>BvG</sup>	Alrex <sup>BvG</sup>
Dexamethasone Sodium Phosphate	Difluprednate
Durezol <sup>BvG</sup>	Flarex
Flarex	Inveltys
Fluorometholone	Lotemax <sup>BvG</sup>
Fml Forte	Lotemax SM
Fml S.O.P.	Loteprednol
Lotemax <sup>BvG</sup>	Maxidex
Maxidex	
Pred Forte	
Pred Mild	
Prednisolone Acetate	
Prednisolone Sodium Phosphate	

[Link to Criteria: Ophthalmic Agents: Ophthalmic Steroids](#)

Otic Agents: Antibacterial and Antibacterial/Steroid Combinations	
PREFERRED	NON-PREFERRED
Cipro HC	Ciprofloxacin
Ciprodex <sup>BvG</sup>	Ciprofloxacin/Dexamethasone
Cortisporin-TC	Ciprofloxacin/Fluocinolone
Neomycin/Polymyxin B/Hydrocortisone	
Ofloxacin	

[Link to Criteria: Otic Agents: Antibacterial and Antibacterial/Steroid Combinations](#)

Respiratory Agents: Antihistamines – Second Generation	
PREFERRED	NON-PREFERRED
Cetirizine Syr, Tab <sup>QL</sup>	Cetirizine Chewable <sup>AR</sup>
Cetirizine/Pseudoephedrine	Clarinet-D
Loratadine Rapid Dissolve <sup>QL</sup>	Desloratadine
Loratadine Syr, Tab <sup>QL</sup>	Fexofenadine
Loratadine/Pseudoephedrine	Levocetirizine

[Link to Criteria: Respiratory Agents: Antihistamines – Second Generation](#)

Respiratory Agents: Cystic Fibrosis	
PREFERRED	NON-PREFERRED
Kalydeco <sup>PA QL</sup>	Bronchitol
Orkambi <sup>PA QL</sup>	
Symdeko <sup>PA QL</sup>	
Trikafta <sup>PA</sup>	

[Link to Criteria: Respiratory Agents: Cystic Fibrosis](#)

Respiratory Agents: Epinephrine Auto-Injectors	
PREFERRED	NON-PREFERRED
Epinephrine (labeler 49502)	Epipen
Symjepi	Epipen JR

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**Link to Criteria: Respiratory Agents: Epinephrine Auto-Injectors**

Respiratory Agents: Hereditary Angioedema	
PREFERRED	NON-PREFERRED
Haegarda <sup>PA</sup>	Berinert
Ruconest <sup>PA</sup>	Cinryze
Takhzyro <sup>PA</sup>	Icatibant Acetate
	Kalbitor

**Link to Criteria: Respiratory Agents: Hereditary Angioedema**

Respiratory Agents: Inhaled Agents	
PREFERRED	NON-PREFERRED
Advair Diskus <sup>BvG</sup>	Aerospan HFA
Advair HFA	Airduo Digihaler, Respiclick
Albuterol Nebulizer Sol 0.021% (0.63mg/3mL), 0.042% (1.25mg/3mL) <sup>AR</sup>	Albuterol HFA
Albuterol Nebulizer Sol 0.083% (2.5mg/3mL), 0.5% (5mg/mL) Conc	Alvesco
Anoro Ellipta	Armonair Digihaler, Respiclick
Asmanex Twisthaler	Arnuity Ellipta
Atrovent HFA <sup>QL</sup>	Asmanex HFA
Budesonide Nebulizer Sol <sup>AR QL</sup>	Bevespi Aerosphere
Combivent Respimat	Breo Ellipta <sup>BvG</sup>
Cromolyn Neb Sol	Breztri Aerosphere
Dulera	Brovana <sup>BvG</sup>
Flovent <sup>BvG QL</sup>	Budesonide/Formoterol
Incruse Ellipta	Duaklir Pressair
Ipratropium	Fluticasone/Salmeterol
Ipratropium/Albuterol Nebulizer Sol <sup>QL</sup>	Levalbuterol Nebulizer Sol
ProAir Proventil HFA <sup>BvG</sup>	Lonhala Magnair
Pulmicort Flexhaler <sup>QL</sup>	Formoterol Fumarate Nebulizer Sol Performist <sup>BvG</sup>
Serevent Diskus	Proair Digihaler, Respiclick
Spiriva <sup>QL</sup>	Proventil
Stiolto	Qvar <sup>QL</sup>
Striverdi Respimat	Trelegy Ellipta
Symbicort <sup>BvG QL</sup>	Tudorza
Ventolin HFA <sup>BvG</sup>	Wixela Inhub
	Xopenex HFA
	Yupelri

**Link to Criteria: Respiratory Agents: Inhaled Agents**

Respiratory Agents: Leukotriene Receptor Modifiers & Inhibitors	
PREFERRED	NON-PREFERRED
Montelukast <sup>QL</sup>	Zileuton
Zafirlukast <sup>ST</sup>	Zyflo

**Link to Criteria: Respiratory Agents: Leukotriene Receptor Modifiers & Inhibitors**

Respiratory Agents: Monoclonal Antibodies-Anti-IL/Anti-IgE	
PREFERRED	NON-PREFERRED
Fasenra <sup>PA</sup>	Dupixent
Dupixent <sup>PA</sup>	Nucala
Nucala <sup>PA</sup>	Tezspire
Xolair <sup>PA</sup>	

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[Link to Criteria: Respiratory Agents: Monoclonal Antibodies-Anti-IL/Anti-IgE](#)

Respiratory Agents: Nasal Preparations	
PREFERRED	NON-PREFERRED
Azelastine	Azelastine/Fluticasone Spray
Flunisolide	Beconase AQ
Fluticasone (Generic of Flonase)	Budesonide
Ipratropium <sup>QL</sup>	Mometasone
Olopatadine	Omnaris
	Qnasl
	Xhance
	Zetonna

[Link to Criteria: Respiratory Agents: Nasal Preparations](#)

Respiratory Agents: Other Agents	
PREFERRED	NON-PREFERRED
	Daliresp

[Link to Criteria: Respiratory Agents: Other Agents](#)

Topical Agents: Antifungals	
PREFERRED	NON-PREFERRED
Alevazol	Butenafine
Ciclopirox	Ciclopirox Kit
Clotrimazole	Ertaczo
Clotrimazole/Betamethasone	Jublia
Econazole	Ketoconazole Foam
Ketoconazole	Luliconazole
Miconazole	Miconazole/Zinc Oxide/White Petrolatum Oint
Nystatin	Naftifine
Nystatin/Triamcinolone	Oxiconazole
Terbinafine	Tavaborole
Tolnaftate	

[Link to Criteria: Topical Agents: Antifungals](#)

Topical Agents: Antiparasitics	
PREFERRED	NON-PREFERRED
Natroba <sup>BvG</sup>	Eurax
Permethrin	Malathion
Piperonyl Butoxide/Pyrethrins	Sklice
	Spinosad

[Link to Criteria: Topical Agents: Antiparasitics](#)

Topical Agents: Corticosteroids	
PREFERRED	NON-PREFERRED
Amcinonide	Alclometasone
Betamethasone Dip/Calcipotriene Oint	Apexicon E
Betamethasone Valerate	Betamethasone Dipropionate
Clobetasol Propionate	Betamethasone Dipropionate/Calcipotriene Susp
Derma-Smoothe/FS <sup>BvG</sup>	Betamethasone Valerate Aerosol Foam

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### Topical Agents: Corticosteroids

PREFERRED	NON-PREFERRED
Desonide Cream, Oint	Bryhali
Diflorasone Diacetate	Clocortolone Pivalate
Fluocinolone Acetonide 0.01% Cream, Sol, 0.05%	Cordran Tape
Flurandrenolide	Desonate Gel
Fluticasone Propionate Cream, Oint	Desonide Lotion
Hydrocortisone	Desoximetasone
Mometasone Furoate	Fluocinolone Acetonide 0.01% Oil
Prednicarbate	Fluocinolone Acetonide 0.025%, 0.1%
Triamcinolone	Fluticasone Propionate Lotion
	Halcinonide Cream
	Halobetasol Propionate
	Hydrocortisone Butyrate, Valerate
	Halog
	Impeklo
	Pandel

[Link to Criteria: Topical Agents: Corticosteroids](#)

### Topical Agents: Immunomodulators

PREFERRED	NON-PREFERRED
Elidel <sup>AR BvG ST</sup>	Eucrisa
Tacrolimus <sup>AR ST</sup>	Opzelura
	Pimecrolimus <sup>AR</sup>
	Vtama

[Link to Criteria: Topical Agents: Immunomodulators](#)

## Ohio Medicaid

AR = Age Restriction QL = Quantity Limit ST = Step Therapy Required PA = Clinical Prior Authorization Required BvG = Brand Preferred Over Generic



Department of  
Medicaid

# Unified Preferred Drug List

Medicaid Fee-for-Service  
and Managed Care Plans

Effective January 1, 2023

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## Helpful Links

### **Prior Authorization (PA)**

[Prior Authorization \(PA\) Information | pharmacy.medicaid.ohio.gov](https://pharmacy.medicaid.ohio.gov/prior-authorization)

### **Unified Preferred Drug List (UPDL)**

[Ohio Unified Preferred Drug List | pharmacy.medicaid.ohio.gov](https://pharmacy.medicaid.ohio.gov/unified-preferred-drug-list)

AR = Age Restriction QL = Quantity Limit ST = Step Therapy Required PA = Clinical Prior Authorization Required BvG = Brand Preferred Over Generic



- 
- General Prior Authorization Requirements
  - PA and Step Therapy Frequently Asked Questions (FAQ)
  - Unified Preferred Drug List (UPDL)
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## General Information

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- The Statewide UPDL is not an all-inclusive list of drugs covered by Ohio Department of Medicaid.
  - Medications that are new to market will be non-preferred, PA required until reviewed by the Ohio Department of Medicaid Pharmacy and Therapeutics (P&T) Committee.
  - The document is listed in sections defined by therapeutic class. Drugs are listed by generic name if a generic is available unless the brand name of the drug is preferred. In most cases, when a generic for a brand-name drug is available, the generic drug will be preferred, and the brand name will be non-preferred. Some drugs may also require a specific manufacturer or the brand to be dispensed.
  - Ohio Department of Medicaid will only cover drugs that are part of the Medicaid Drug Rebate Program, with limited exceptions. This document may not reflect the most current rebate status of a drug (i.e., a drug may be listed on the document but is non-rebateable and therefore non-payable).
  - Some therapeutic categories are grandfathered. These categories will be denoted with an “\*” next to their title on the table on contents and their place within the criteria document.
  - Some therapeutic categories may have quantity limits on specific drugs detailed in the criteria document, however this is not an all-inclusive list. For a list of the quantity limits on specific drugs, please reference the Quantity Limit Document found here: [Quantity Limits Document | pharmacy.medicaid.ohio.gov](https://pharmacy.medicaid.ohio.gov/QuantityLimitsDocument)
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## Terminology/Abbreviations:

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**AR** (Age Restriction) – An edit allowing claims for members within a defined age range to be covered without PA  
**BvG** (Brand Preferred Over the Generic) – The brand name drug is preferred over the generic equivalent  
**PA** (Clinical Prior Authorization) – A prior authorization (PA) is required before the drug will be covered  
**QL** (Quantity Limit) – A limit on the quantity that will be covered within a given time frame  
**ST** (Step Therapy) – Drug requires a trial with one or more preferred drugs before being covered

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## New UPDL Criteria Format

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- With a few minor exceptions, all therapeutic categories have the same standardized outline format. The design of this new format is intended to have a cumulative approach bottom-to-top.

### Example Category

**LENGTH OF AUTHORIZATIONS:** X days or Initial: X days; Subsequent: X days (if different)

**GRANDFATHERING\*:**

Patients who have a claim for a non-preferred drug in the previous 120 days will be automatically approved to continue the drug. Patients who have taken the drug previously, but do not have claims history (e.g. new to Medicaid), will need to submit a prior authorization in order to continue coverage.

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**CLINICAL PA CRITERIA (if applicable):**

**“DRUG” CRITERIA (if applicable):**

**STEP THERAPY CRITERIA:**

- Must have had an inadequate clinical response of at least X days with at least X preferred drugs

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least X days with X preferred drugs
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**ADDITIONAL “DRUG” CRITERIA (if applicable):**

**ADDITIONAL INFORMATION (if applicable):**

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient’s response to treatment from baseline and/or attestation of clinical stabilization

**QL** – Drug: X doses per X days

**AR** – a PA is required for patients X years and older **OR** younger than X years

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## Interpretation of New UPDL Criteria Format

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- Beginning January 2023 and with a few minor exceptions, all therapeutic categories have the same standardized outline format. The design of this new format is intended to have a cumulative approach bottom-to-top. The following scenarios will aid in illustrating this point:

### **Scenario 1: Clinical PA drug**

- All Authorizations
- Clinical PA Criteria

### **Scenario 2: Clinical PA drug with drug-specific criteria**

- All Authorizations
- Drug-Specific Criteria

### **Scenario 3: Step-Therapy drug**

- All Authorizations
- Clinical PA Criteria (if applicable)
- Step Therapy Criteria

### **Scenario 4: Non-Preferred drug**

- All Authorizations
- Clinical PA Criteria (if applicable)
- Step Therapy Criteria (if applicable)
- Non-Preferred Criteria

### **Scenario 5: Non-Preferred drug with drug-specific criteria**

- All Authorizations
  - Clinical PA Criteria (if applicable)
  - Step Therapy Criteria (if applicable)
  - Non-Preferred Criteria
  - Additional Drug-Specific Criteria
-

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AR = Age Restriction QL = Quantity Limit ST = Step Therapy Required PA = Clinical Prior Authorization Required BvG = Brand Preferred Over Generic

## Analgesic Agents: Gout

**LENGTH OF AUTHORIZATIONS:** 365 days except 180 days for Familial Mediterranean Fever

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**CLINICAL PA CRITERIA:**

- Must have had an inadequate clinical response with an NSAID and oral corticosteroid within the last 30 days for acute gout diagnosis **OR**
- Must have had an inadequate clinical response of at least 30 days with the maximally tolerated xanthine oxidase inhibitor dose for chronic gout diagnosis

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least one preferred drug
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**ADDITIONAL COLCHICINE CAPSULE (MITIGARE) CRITERIA:**

- Must have had an inadequate clinical response of 30 days with colchicine tablets

**ADDITIONAL COLCHICINE SOLUTION (GLOPERBA) CRITERIA:**

- Must be unable to swallow tablets or capsules for authorization of colchicine solution

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

**QL** – All colchicine products: 6 doses per claim for acute gout; 2 doses per day for 30 days for chronic gout; 4 doses per day per 30 days for Familial Mediterranean Fever

## Analgesic Agents: NSAIDs

**LENGTH OF AUTHORIZATIONS:** Dependent upon the table below

	Authorization Length
H. Pylori Treatment	30 days
Transdermal/Topical	90 days
All Other Treatments	365 days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

**AR** – Naproxen Suspension: a PA is required for patients 12 years old and older

# Analgesic Agents: Opioids

*\*\*Ohio law requires prescribers to request and review an OARRS report before initially prescribing or personally furnishing any controlled substance, such as an opioid analgesic or a benzodiazepine, and gabapentin\*\**

**LENGTH OF AUTHORIZATIONS:** For the course of therapy, up to 180 days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 7 days of at least two unrelated preferred drugs
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**ADDITIONAL SHORT-ACTING OPIOIDS CRITERIA FOR NEW STARTS:**

- The system defines an “initial request” as having no opioid claims in the previous 90 days
- **Initial short-acting requests** can be authorized up to 90 days
  - Length of authorization is dependent on indication, previous patient utilization, and requested length of therapy (could be more restrictive)
  - To exceed acute opioid limits, documentation of the following must be provided:
    - Diagnosis code which must be for somatic type pain
    - Prescriber attestation that the benefits and risks of opioid therapy has been discussed with patient
  - Exemptions to the additional criteria:
    - Patients receiving short-acting opioids for active cancer treatment, palliative care, and end-of-life/hospice care, sickle cell, severe burn, traumatic crushing of tissue, amputation, major orthopedic surgery
    - Prescriber attestation that patient is not opioid naïve (i.e., new to Medicaid or was on higher dose in hospital)
- **Subsequent short-acting requests** can be authorized up to 180 days
  - Documentation of the following must be provided:
    - Current treatment plan
    - Demonstrated adherence to treatment plan through progress notes, including pain and function scores, random urine screenings results reviewed, concerns addressed, and no serious adverse outcomes observed
- **Dose escalation requests** can be authorized up to 180 days

AR = Age Restriction QL = Quantity Limit ST = Step Therapy Required PA = Clinical Prior Authorization Required BvG = Brand Preferred Over Generic



- Documentation of the following must be provided:
  - Prescriber attestation that dose escalation is likely to result in improved function and pain control
  - Requests for a cumulative daily dose >100 MED must be prescribed by or in consultation with a pain specialist or anesthesiologist consultation

*Effective July 1, 2018, patients with short acting opioid therapy will be limited to 30 MED per day and a maximum of 7 days per prescription. Prior authorization will be required to exceed these limits.*

#### **ADDITIONAL LONG-ACTING OPIOIDS CRITERIA:**

- The system defines an “initial request” as having no opioid claims in the previous 90 days
- **Initial long-acting requests** can be authorized up to 90 days
  - Documentation of the following must be provided:
    - Request is a daily dose equivalent of  $\leq 80$  MED
    - Inadequate clinical response to both non-opioid pharmacologic and non-pharmacologic treatments
    - History of short-acting opioids for  $\geq 60$  days
    - Treatment plan including risk assessment, substance abuse history, concurrent therapies, and requirements for random urine screenings (baseline urine drug tests must be submitted)
    - Pain and function scores at each visit
    - Opioid contract required to be in place and submitted with PA form
  - Exemptions to the additional criteria:
    - Patients receiving long-acting opioids for catastrophic injury or cancer pain
- **Subsequent long-acting requests** can be authorized up to 180 days
  - Documentation of the following must be provided:
    - Current treatment plan
    - Demonstrated adherence to treatment plan through progress notes, including pain and function scores, random urine screenings results reviewed, concerns addressed, and no serious adverse outcomes observed
- **Dose escalation requests** can be authorized up to 180 days
  - Documentation of the following must be provided:
    - Prescriber attestation that dose escalation is likely to result in improved function and pain control
    - Requests for a cumulative daily dose >100 MED must be prescribed by or in consultation with a pain specialist or anesthesiologist consultation

#### **ADDITIONAL TRANSMUCOSAL FENTANYL CRITERIA:**

- Must be prescribed by an oncologist, pain specialist, or hospice/palliative prescriber
- Must be concurrently taking a long-acting opioid at a therapeutic dose of any of the following for at least 7 days without adequate pain relief:

AR = Age Restriction QL = Quantity Limit ST = Step Therapy Required PA = Clinical Prior Authorization Required BvG = Brand Preferred Over Generic

≥ 60 mg oral morphine/day  
≥ 25 mcg/hr transdermal fentanyl  
≥ 30 mg oral oxycodone/day

≥ 8 mg oral hydromorphone/day  
≥ 25 mg oral oxymorphone/day  
Equianalgesic dose of another opioid

**QL** – Transmucosal Fentanyl: 4 doses per day

DRAFT

# Blood Formation, Coagulation, and Thrombosis Agents: Colony Stimulating Factors

**LENGTH OF AUTHORIZATIONS:** Dependent upon diagnosis below

Diagnosis	Authorization Length
Acute Myeloid Leukemia (AML)	14 days or duration of chemotherapy regimen
Malignancy at risk for febrile neutropenia or undergoing myeloablative chemotherapy prior to allogeneic or autologous bone marrow transplantation	14 days or duration of chemotherapy regimen
Myeloid Engraftment for bone marrow transplant (BMT)	30 days
Severe, chronic neutropenia with absolute neutrophil count (ANC) of less than 500/mm <sup>3</sup> and have symptoms associated with neutropenia (e.g., fever, infections, oropharyngeal ulcers).	30 days
Hematopoietic radiation injury syndrome	30 days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 14 days with at least one preferred drug
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

# Blood Formation, Coagulation, and Thrombosis Agents: Hematopoietic Agents

**LENGTH OF AUTHORIZATIONS:** Dependent upon diagnosis below

**Authorization of epoetin alfa or darbepoetin:**

Diagnosis	Hemoglobin Level	Authorization Length
Anemia due to chronic renal failure, patient on dialysis	≤11	365 days
Anemia due to chronic renal failure, patient not on dialysis	≤10	365 days
Chemotherapy-induced anemia	≤10	90 days
Anemia in myelodysplastic syndrome	≤11	180 days

**Authorization of epoetin alfa ONLY:**

Diagnosis	Hemoglobin Level	Authorization Length
Autologous blood donation, patient will require blood transfusions	>10 to ≤13	30 days
Anemia of prematurity, age ≤6 months	N/A	42 days
Anemia associated with chronic inflammatory disorders (e.g., rheumatoid arthritis)	≤11	180 days
Anemia associated with ribavirin combination therapy in hepatitis C-infected patient	≤11	180 days
Anemia in zidovudine-treated HIV-infected patients	≤11	180 days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 14 days with at least one preferred drug
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

# Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia Factors\*

**LENGTH OF AUTHORIZATIONS:** 365 Days

**GRANDFATHERING\*:**

Patients who have a claim for a non-preferred drug in the previous 120 days will be automatically authorized to continue the drug. Patients who have taken the drug previously, but do not have claims history (e.g., new to Medicaid), will need to submit a prior authorization in order to continue coverage.

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**CLINICAL PA CRITERIA:**

- Must provide documentation of patient's body weight

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least **14 days** with at least **one preferred** drug
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**ADDITIONAL EXTENDED HALF-LIFE FACTOR CRITERIA**

- Must provide attestation that the patient is not a suitable candidate for treatment with a shorter-acting half-life drug

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

# Blood Formation, Coagulation, and Thrombosis Agents: Heparin-Related Preparations

**LENGTH OF AUTHORIZATIONS:** Dependent upon criteria below

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 14 days with at least one preferred drug
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**ADDITIONAL INFORMATION:**

- For most indications: Guidelines from the American College of Chest Physicians limit duration of therapy in the outpatient setting for most indications to less than 35 days and patients should be transitioned to oral warfarin as soon as possible
- For requests over 35 days and/or the patient cannot be transitioned to warfarin, prescriber must submit additional documentation for reasoning:
  - For patients with cancer – authorized up to 180 days
  - For pregnant women – authorized up to 280 days
  - For patients unable to take warfarin – authorized up to 180 days

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

## Blood Formation, Coagulation, and Thrombosis Agents: Oral Anticoagulants

**LENGTH OF AUTHORIZATION:** 365 days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

## Blood Formation, Coagulation, and Thrombosis Agents: Oral Antiplatelet

**LENGTH OF AUTHORIZATION:** 365 days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring



# Cardiovascular Agents: Angina, Hypertension & Heart Failure

**LENGTH OF AUTHORIZATIONS:** 365 days except nimodipine: 21 days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

## **PROPRANOLOL ORAL SOLUTION (HEMANGEOL) CRITERIA:**

- Must provide documentation of the patient's weight

## **SACUBITRIL/VALSARTAN (ENTRESTO) CRITERIA:**

- Must provide documentation of chronic heart failure classified as either NYHA Class II-IV or ACC/AHA Stage B-D

## **NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days of at least two preferred drugs within the same class, if indicated for diagnosis
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

## **ADDITIONAL FINERENONE (KERENDIA) CRITERIA:**

- Must be on a maximally tolerated dose of an angiotensin-converting enzyme inhibitor or angiotensin receptor blocker
- Must provide documentation of an inadequate clinical response to a SGLT2 Inhibitor **OR** provide documentation of medical necessity beyond convenience for why the patient cannot try a SGLT2 inhibitor (i.e., chronic kidney disease diagnosis)

## **ADDITIONAL MAVACAMTEN (CAMZYOS) CRITERIA:**

- Must be prescribed by or in consultation with a cardiologist
- Must provide documentation of NYHA Class II-III symptoms and left ventricular ejection fraction  $\geq 55\%$

## **ADDITIONAL VERICIGUAT (VERQUVO) CRITERIA:**

- Must provide documentation of ejection fraction
- Must have been hospitalized for the treatment of heart failure in the previous 180 days or needs treatment with an outpatient intravenous diuretic in the previous 90 days

- Must be treated with an agent from **ALL** the following unless contraindicated:
  - Angiotensin-converting enzyme inhibitor, angiotensin II receptor blocker, **OR** an angiotensin receptor neprilysin inhibitor
  - Beta-blocker
  - Aldosterone antagonist and/or SGLT2 inhibitor as appropriate for renal function

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

**AR** – Sotylize Solution: a PA is required for patients 6 years and older

## Cardiovascular Agents: Antiarrhythmics

**LENGTH OF AUTHORIZATIONS:** 365 Days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least one preferred drug
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

# Cardiovascular Agents: Lipotropics

## **LENGTH OF AUTHORIZATIONS:** See below

Juxtapid (Initial)	180 days
Vascepa, Lovaza, ACL inhibitors (Initial)	84 days
All others (Initial and Subsequent)	365 days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

## **CLINICAL PA CRITERIA:**

- Must provide documentation of baseline labs **AND** have documented adherence to 90 days of prescribed lipid lowering medications
- Must have had an inadequate clinical response of at least 90 days **AND** unable to reach goal LDL-C (see below) despite treatment with maximally tolerated dose of high-potency statin and ezetimibe (or a clinical reason that these drugs cannot be utilized)

## **NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days (or 90 days for fibrates) with at least one preferred drug in the same drug class
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

## **ADDITIONAL LOVASTATIN ER (ALTOPREV), PITAVASTATIN (LIVALO), FLUVASTATIN (LESCOL) CRITERIA**

- Must have had an inadequate clinical response of at least 30 days with two preferred drugs in the same drug class

## **ADDITIONAL COLESEVELAM (WELCHOL) CRITERIA:**

- Must provide documentation of a Type 2 Diabetes diagnosis

## **ADDITIONAL ICOSAPENT ETHYL (VASCEPA) CRITERIA:**

- Must provide documentation of baseline labs indicating triglyceride levels  $\geq 500\text{mg/dL}$  after an inadequate clinical response to fibrates, niacin, and diet/exercise
- Must provide documentation of discontinuation of drugs known to increase triglyceride levels (i.e., beta blockers, thiazides, and estrogens), if clinically appropriate

## **ADDITIONAL LOMITAPIDE (JUXTAPID) & ATP CITRATE LYASE (ACL) INHIBITOR CRITERIA:**

AR = Age Restriction QL = Quantity Limit ST = Step Therapy Required PA = Clinical Prior Authorization Required BvG = Brand Preferred Over Generic

- Must provide documentation of baseline labs **AND** have documented adherence to 90 days of prescribed lipid lowering medications
- Must have had inadequate clinical response of at least 90 days **AND** unable to reach goal LDL-C with high-potency statin, ezetimibe and PCSK9 inhibitor (or a clinical reason that these drugs cannot be utilized)

**ADDITIONAL INFORMATION:**

- High potency statins: atorvastatin (Lipitor) 40-80mg & rosuvastatin (Crestor) 20-40mg
- LDL goals for Familial Hypercholesterolemia (includes Heterozygous & Homozygous FH): LDL  $\leq$  100mg/dL for adults or LDL  $\leq$  110mg/dL for those < 18 years of age
- LDL goals for Clinical Atherosclerotic Cardiovascular Disease (ASCVD): LDL  $\leq$  70mg/dL

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

# Cardiovascular Agents: Pulmonary Arterial Hypertension\*

**LENGTH OF AUTHORIZATIONS:** 365 Days

**GRANDFATHERING\*:**

Patients who have a claim for a non-preferred drug in the previous 120 days will be automatically approved to continue the drug. Patients who have taken the drug previously, but do not have claims history (e.g., new to Medicaid), will need to submit a prior authorization in order to continue coverage.

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**CLINICAL PA CRITERIA:**

- Must provide documentation of NYHA Functional Class for Pulmonary Hypertension and symptoms experienced by patient

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs, one of which must be a phosphodiesterase-5 inhibitor
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**ADDITIONAL INFORMATION:**

- Patients who have class III or IV symptoms defined by the NYHA Functional Class for Pulmonary Hypertension may be authorized for inhalation or intravenous agents

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

**AR** - Sildenafil Oral Solution: a PA is required for patients 6 years and older

## Central Nervous System (CNS) Agents: Alzheimer's Agents\*

**LENGTH OF AUTHORIZATIONS:** 365 Days

**GRANDFATHERING\*:**

Patients who have a claim for a non-preferred drug in the previous 120 days will be automatically approved to continue the drug. Patients who have taken the drug previously, but do not have claims history (e.g., new to Medicaid), will need to submit a prior authorization in order to continue coverage.

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

**AR** – All drugs: a PA is required for patients younger than 40 years

## Central Nervous System (CNS) Agents: Anti-Migraine Agents, Acute

**LENGTH OF AUTHORIZATIONS:** 180 Days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**STEP THERAPY CRITERIA:**

- Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**ADDITIONAL UBROGEPANT (UBRELVY) CRITERIA**

- Must have had an inadequate clinical response of at least 14 days with at least one preferred oral CGRP antagonist

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

QL - Nurtec ODT: 8 doses per 30 days for acute treatment



# Central Nervous System (CNS) Agents: Anti-Migraine Agents, Cluster Headache

**LENGTH OF AUTHORIZATIONS:** 180 days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- **Must have had an inadequate clinical response of at least 60 days to at least one preferred drug**
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**ADDITIONAL INFORMATION:**

- An inadequate clinical response to verapamil is defined as a titration to at least 480mg daily

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

# Central Nervous System (CNS) Agents: Anti-Migraine Agents, Prophylaxis

**LENGTH OF AUTHORIZATIONS:** Initial: 180 days; Subsequent: 365 days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**STEP THERAPY CRITERIA:**

- Must have had an inadequate clinical response of at least 30 days with at least three preferred controller migraine drugs
- Must include objective documentation of severity, frequency, type of migraine, and number of headache days per month (preferably a headache diary)

**ERENUMAB (AIMOVIG) CRITERIA:**

- Must have had an inadequate clinical response of at least 60 days with the 70mg dose to request a dose increase

**FREMANEZUMAB (AJOVY) CRITERIA:**

- Must have demonstrated efficacy for at least 90 days before quarterly administration will be authorized

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least three preferred controller migraine drugs **AND one step therapy** drug
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**ADDITIONAL INFORMATION:**

- Controller migraine drug classes include beta-blockers, anticonvulsants, tricyclic antidepressants, or serotonin-norepinephrine reuptake inhibitors

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment (preferably a headache diary or other objective documentation of severity, frequency, and number of headache days per month).

**QL - Nurtec ODT:** 18 doses per 30 days for prophylactic treatment

**QL – Aimovig, Emgality, Ajovy:** 1 dose per 30 days

AR = Age Restriction QL = Quantity Limit ST = Step Therapy Required PA = Clinical Prior Authorization Required BvG = Brand Preferred Over Generic

# Central Nervous System (CNS) Agents: Anticonvulsants\*

**LENGTH OF AUTHORIZATIONS:** 365 days except Epidiolex and Diacomit – Initial: 180 days

**GRANDFATHERING\*** (except ~~Epidiolex and Diacomit~~):

Patients who have a claim for a non-preferred drug in the previous 120 days will be automatically approved to continue the drug. Patients who have taken the drug previously, but do not have claims history (e.g., new to Medicaid), will need to submit a prior authorization in order to continue coverage.

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**STEP THERAPY CRITERIA:**

- Must have had an inadequate clinical response of at least 30 days with at least one preferred drug

**CANNABIDIOL (EPIDIOLEX) CRITERIA**

- Must have had an inadequate clinical response of at least 30 days with any two of the following anticonvulsants: clobazam, levetiracetam, valproic acid, lamotrigine, topiramate, rufinamide, or felbamate within the past 365 days (members who meet this criteria will not require a PA)
- ~~Must have had an inadequate clinical response (inadequate seizure control or intolerance) of at least 30 days with three preferred anticonvulsant drugs (Note: not required for Dravet Syndrome)~~
- ~~Must provide documentation of serum transaminases (ALT and AST) and total bilirubin levels prior to starting therapy~~
- ~~Must provide documentation of patient's weight~~
  - ~~Maximum daily dose does not exceed: 20mg/kg/day for Lennox-Gastaut syndrome or Dravet syndrome or 25mg/kg/day for Tuberous sclerosis complex (titration based on response/tolerability)~~
- ~~Must provide baseline average number of seizure days per month (measured monthly or quarterly)~~

**STIRIPENTOL (DIACOMIT) CRITERIA**

- Must be prescribed by or in consultation with a neurologist
- Must be concomitantly taking clobazam (Onfi)
- Must provide documentation of addressed comorbidities and baseline hematologic testing (CBC)
  - Patients with phenylketonuria (PKU) must provide evidence of total daily amount of phenylalanine
  - Prescribers must include management plans for patients with neutrophil counts <1,500 cells/mm<sup>3</sup> or platelet count <150,000/μL
- Must provide documentation of patient's weight
  - Maximum daily dose does not exceed: 50 mg/kg/day or 3,000mg/day
- Must provide baseline average number of seizure days per month (measured monthly or quarterly)

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)
- Prescriptions submitted from a prescriber who is registered as a neurology specialty with Ohio Medicaid AND for drugs that are used only for seizures, there must have been an inadequate clinical response of at least 30 days with one preferred drug. *This provision applies only to the standard tablet/capsule dosage form and does not apply to brand products with available generic alternatives.*

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring (i.e., documented reduction in average number of seizure days per month [measured monthly or quarterly])

**AR** – Vigabatrin Powder: a PA is required for patients 3 years and older

**AR** – Eprontia Solution: a PA is required for patients 12 years and older

## Central Nervous System (CNS) Agents: Anticonvulsants Rescue

**LENGTH OF AUTHORIZATIONS:** 365 Days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- **Must have had an inadequate clinical response with at least one preferred drug**
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

**AR** – Valtoco: a PA is required for patients younger than 6 years old

**AR** – Nayzilam: a PA is required for patients younger than 12 years old

## Central Nervous System (CNS) Agents: Antidepressants\*

**LENGTH OF AUTHORIZATIONS:** 365 Days

**GRANDFATHERING\*:**

Patients who have a claim for a non-preferred drug in the previous 120 days will be automatically approved to continue the drug. Patients who have taken the drug previously, but do not have claims history (e.g., new to Medicaid), will need to submit a prior authorization in order to continue coverage.

**PSYCHIATRIST EXEMPTION:**

Prescribers (as identified below) are exempt from prior authorization of any non-preferred antidepressant, or step therapy of any preferred brand, in the standard tablet/capsule dosage forms. Other dosage forms may still require prior authorization. The exemption will be processed by the claims system when the pharmacy has submitted the prescriber on the claim using the individual national provider identifier (NPI) for the prescriber.

**FFS:** Physicians who are registered with Ohio Medicaid as having a specialty in psychiatry

**MCOs:** Physicians with a specialty in psychiatry, nurse practitioners certified in psychiatric mental health, or clinical nurse specialists certified in psychiatric mental health, who are credentialed via the Medicaid managed care plan

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

# Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents

**LENGTH OF AUTHORIZATIONS:** 365 days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**STEP THERAPY CRITERIA:**

- Must have had an inadequate clinical response of at least **30 days** with atomoxetine **OR** at least **two preferred stimulants**

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least **30 days** with at least **three preferred** drugs
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**ADDITIONAL INFORMATION**

- Requests for non-preferred immediate-release formulations must have all required trials with preferred immediate-release drugs, and requests for non-preferred extended-release formulations must have all required trials with preferred extended-release drugs
- For patients established on drugs that change from preferred to non-preferred on January 1, a prior authorization is **NOT** required until **after** June 30<sup>th</sup> of that year.

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

**AR** – Adderall, Dexedrine, & Zenzedi IR: a PA is required for patients younger than 3 years

**AR** – Adderall XR, Atomoxetine, Cotelma XR-ODT, Daytrana, Dexedrine ER, Dexamethylphenidate & Methylphenidate IR & ER: a PA is required for patients younger than 6 years

**AR** – Dextroamphetamine Solution & **Dyanavel XR**: a PA is required for patients **12 years and older**

**AR** – Methylphenidate solution/suspension: a PA is required for patients younger than 6 years and 12 years and older

# Central Nervous System (CNS) Agents: Atypical Antipsychotics\*

**LENGTH OF AUTHORIZATIONS:** 365 Days

**GRANDFATHERING\*:**

Patients who have a claim for a non-preferred drug in the previous 120 days will be automatically approved to continue the drug. Patients who have taken the drug previously, but do not have claims history (e.g., new to Medicaid), will need to submit a prior authorization in order to continue coverage.

**PSYCHIATRIST EXEMPTION:**

Prescribers (as identified below) are exempt from prior authorization of any non-preferred second-generation antipsychotic, or step therapy of any preferred brand, in the standard tablet/capsule dosage forms. Other dosage forms may still require prior authorization. The exemption will be processed by the claims system when the pharmacy has submitted the prescriber on the claim using the individual national provider identifier (NPI) for the prescriber.

**FFS:** Physicians who are registered with Ohio Medicaid as having a specialty in psychiatry

**MCOs:** Physicians with a specialty in psychiatry, nurse practitioners certified in psychiatric mental health, or clinical nurse specialists certified in psychiatric mental health, who are credentialed via the Medicaid managed care plan

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**PALIPERIDONE PALMITATE (INVEGA HAFYERA) CRITERIA:**

- Must have had 4 months of treatment with Invega Sustenna or 3 months with Invega Trinza

**STEP THERAPY CRITERIA:**

- Must have had an inadequate clinical response of at least 30 days with at least one preferred drug

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**ADDITIONAL ARIPIPRAZOLE (ABILIFY MYCITE) CRITERIA:**



- Must be prescribed by **or in consultation with** a psychiatrist following an aripiprazole serum blood level draw indicating need for further investigation of adherence

#### **ADDITIONAL OLANZAPINE/SAMIDORPHAN (LYBALVI) CRITERIA:**

- Must provide documentation that patient is not using opioids or undergoing acute opioid withdrawal

#### **ADDITIONAL PIMAVANSERIN (NUPLAZID) CRITERIA:**

- **For Parkinson-related Hallucinations & Delusions ALL of the following must be met:**
  - Psychotic symptoms are severe and frequent enough to warrant treatment with an antipsychotic **AND** are not related to dementia or delirium
  - The patient's other Parkinson's Disease drugs have been reduced or adjusted and psychotic symptoms persist **OR** patient is unable to tolerate adjustment of these other drugs
  - Must have been inadequate clinical response or contraindication to at least 30 days of either quetiapine or clozapine
- An exemption to the criteria will be authorized for prescribers with a neurology specialty to a patient with a history of the related condition

#### **ADDITIONAL FLUOXETINE/OLANZAPINE (SYMBYAX) CRITERIA**

- **Must provide documentation for patient's inability to use the individual drugs**

#### **ADDITIONAL INFORMATION**

- Long-acting injectable antipsychotics may be billed by the pharmacy if they are not dispensed directly to the patient. If not administered by the pharmacist, the drug must be released only to the administering provider or administering provider's staff, following all regulations for a Prescription Pick-Up Station as described by the Ohio Board of Pharmacy

#### **SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

## Central Nervous System (CNS) Agents: Fibromyalgia Agents

**LENGTH OF AUTHORIZATIONS:** 365 Days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs in different classes (see Additional Information section below)
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**ADDITIONAL INFORMATION**

- Drugs and drug classes include gabapentin, pregabalin, short- and/or long-acting opioids, skeletal muscle relaxants, SNRIs, SSRIs, trazodone, and tricyclic antidepressants
- The P&T Committee does not recommend the use of opioids for treatment of fibromyalgia

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

# Central Nervous System (CNS) Agents: Medication Assisted Treatment of Opioid Addiction

**LENGTH OF AUTHORIZATIONS:** 180 days except 14 days for Lucemyra

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**ADDITIONAL LOFEXIDINE (LUCEMYRA) CRITERIA**

- May be authorized if **ALL** of the following criteria are met:
  - Must provide medical justification supporting why an opioid taper (such as with buprenorphine or methadone) cannot be used
  - Must have had an inadequate clinical response or contraindication to clonidine
- Must provide documentation that the drug was initiated in an inpatient setting to be exempt from the above criteria

**BUPRENORPHINE SAFETY EDITS AND DRUG UTILIZATION REVIEW CRITERIA:**

- Prescribing for buprenorphine products must follow the requirements of Ohio Administrative Code rule 4731-33-03 *Office based treatment for opioid addiction*.
- In favor of eliminating prior authorization for all forms of oral short acting buprenorphine-containing products, ODM and the Managed Care Plans will implement safety edits and a retrospective drug utilization review process for all brand and generic forms of oral short acting buprenorphine-containing products. Safety edits are in place for dosages over 24mg of buprenorphine equivalents/day.
- Buprenorphine sublingual tablets (generic Subutex) will be restricted to pregnancy, breastfeeding, or contraindication to preferred products
- Buprenorphine injection (Sublocade) dosing schedule will be limited to 300mg/30 days

**ADDITIONAL INFORMATION**

- Vivitrol and Sublocade may be billed by the pharmacy if it is not dispensed directly to the patient. If not administered by the pharmacist, the drug must be released only to the administering

provider or administering provider's staff, following all regulations for a Prescription Pick-Up Station as described by the Ohio Board of Pharmacy.

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

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# Central Nervous System (CNS) Agents: Movement Disorders

**LENGTH OF AUTHORIZATIONS:** 365 Days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**CLINICAL PA CRITERIA:**

- Must be prescribed by or in consultation with a neurologist or psychiatrist

**STEP THERAPY CRITERIA:**

- Must have an inadequate clinical response of at least 90 days to a maximally tolerated dose of tetrabenazine

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

## Central Nervous System (CNS) Agents: Multiple Sclerosis\*

**LENGTH OF AUTHORIZATIONS:** 365 Days

**GRANDFATHERING\*:**

Patients who have a claim for a non-preferred drug in the previous 120 days will be automatically approved to continue the drug. Patients who have taken the drug previously, but do not have claims history (e.g., new to Medicaid), will need to submit a prior authorization in order to continue coverage.

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least one preferred drug
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**ADDITIONAL SIPONIMOD (MAYZENT) CRITERIA:**

- Must provide documentation of genotype, liver function tests (LFTS) complete blood count (CBC), ophthalmic examination, varicella zoster virus antibodies, and electrocardiogram (ECG)

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

## Central Nervous System (CNS) Agents: Narcolepsy

**LENGTH OF AUTHORIZATIONS:** 365 days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs - either (1) modafinil or armodafinil; or (2) preferred methylphenidate or amphetamine drug
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**ADDITIONAL OXYBATE SALTS (XYWAV) CRITERIA:**

- Must have documented adherence to sodium restricted diet

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

**AR** – Adderall IR: a PA is required for patients younger than 3 years

**AR** – Adderall XR, Dexedrine ER: a PA is required for patients younger than 6 years

**AR** – Methylphenidate: a PA is required for patients younger than 6 years and **12 years and older**

## Central Nervous System (CNS) Agents: Neuropathic Pain

**LENGTH OF AUTHORIZATIONS:** 365 Days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in different drug classes
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring



## Central Nervous System (CNS) Agents: Parkinson's Agents

**LENGTH OF AUTHORIZATIONS:** 365 Days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least one preferred drug
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**ADDITIONAL APOMORPHINE (APOKIN/KYNMOBI), LEVODOPA INHALATION (INBRIJA), & ISTRADEFYLLINE (NOURIANZ) CRITERIA:**

- Must have had inadequate clinical response to at least 30 days with one other drug for the treatment of “off episodes” (dopamine agonist, COMT inhibitor, or MAO-B inhibitor)

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient’s clinical response to treatment and ongoing safety monitoring

# Central Nervous System (CNS) Agents: Restless Legs Syndrome

**LENGTH OF AUTHORIZATIONS:** 365 Days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least one preferred drug
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

## Central Nervous System (CNS) Agents: Sedative-Hypnotics, Non-Barbiturate

**LENGTH OF AUTHORIZATIONS:** 180 Days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 10 days with at least two preferred drugs
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**ADDITIONAL INFORMATION**

- Non-controlled medications may be authorized if the prescriber indicates the patient has a history of addiction
- The P&T Committee does not recommend the use of flurazepam (Dalmane) or triazolam (Halcion)

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

# Central Nervous System (CNS) Agents: Skeletal Muscle Relaxants, Non-Benzodiazepine

**LENGTH OF AUTHORIZATIONS:** 365 Days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least one preferred drug
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics, requests must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**ADDITIONAL BACLOFEN SOLUTION CRITERIA:**

- Must provide documentation of trial with baclofen tablets or justification why a non-solid oral dosage form is indicated

**ADDITIONAL CARISOPRODOL (SOMA) CRITERIA:**

- Must provide medical justification that no other muscle relaxant or agent to treat fibromyalgia, or any musculoskeletal condition would serve the clinical needs of the patient

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

## Central Nervous System (CNS) Agents: Smoking Deterrents

All products are covered without a PA

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## Dermatologic Agents: Oral Acne Products

**LENGTH OF AUTHORIZATIONS:** 150 days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**CLINICAL PA CRITERIA:**

- Must have had an inadequate clinical response of at least 90 days with at least one preferred topical **AND** one preferred oral antibiotic for acne
- Must be absent of oral tretinoin in the past 56 days
- Patient must be registered and meet all of the requirements of the iPLEDGE program

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 90 days with at least two preferred drugs
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**ADDITIONAL INFORMATION**

- Authorization length will be for no more than 150 days at a time then must take 56 days off

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

## Dermatologic Agents: Topical Acne Products

**LENGTH OF AUTHORIZATIONS:** 365 Days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days or (90 days for retinoids) of at least three preferred drugs
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**ADDITIONAL TRETINOIN/BENZOYL PEROXIDE (TWYNEO) CRITERIA**

- Must provide documentation for patient's inability to use the individual drugs

**ADDITIONAL INFORMATION**

- All retinoids - May be authorized with a diagnosis of skin cancer
- Tazarotene (Tazorac) - May be authorized with a diagnosis of psoriasis

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

**AR** - All topical retinoids: a PA is required for patients 24 years and older

## Endocrine Agents: Androgens

**LENGTH OF AUTHORIZATIONS:** 365 Days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**CLINICAL PA CRITERIA:**

- Must provide documentation of lab work to support the need for testosterone supplementation

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 90 days with **ALL preferred** drugs
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring (i.e., testosterone and hematocrit)

AR: All drugs: a PA is required for patients younger than 18 years



## Endocrine Agents: Diabetes – Hypoglycemia Treatments

**LENGTH OF AUTHORIZATIONS:** 365 Days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least two preferred drugs **OR** the inability of the member and/or caregiver to administer a preferred glucagon product in a timely fashion
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

**QL** – All glucagon products: 2 doses per 34 days

## Endocrine Agents: Diabetes – Insulin

**LENGTH OF AUTHORIZATIONS:** 365 Days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**STEP THERAPY CRITERIA:**

- Must have had an inadequate clinical response of at least 120 days with at least one preferred drug **having a similar duration of action**

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 120 days with at least two preferred drugs **having a similar duration of action**
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**ADDITIONAL INHALED INSULIN (AFREZZA) CRITERIA:**

- Must provide documentation of spirometry testing prior to initiation with a predicted FEV1  $\geq 70\%$  - Will not be authorized for patients with asthma or COPD
- Must provide documentation of being nicotine-free for at least 180 days

**ADDITIONAL INFORMATION**

- An inadequate clinical response is defined as the inability to reach A1C goal after at least 120 days of current regimen with documented adherence and appropriate dose escalation.
- Requests may be authorized for patients with a condition that is difficult to control (i.e., prone to ketoacidosis, hypoglycemia)

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

## Endocrine Agents: Diabetes – Non-Insulin

**LENGTH OF AUTHORIZATIONS:** 365 Days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 120 days with at least three preferred drugs
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**ADDITIONAL ORAL AND INJECTABLE COMBINATION DRUGS CRITERIA**

- Must have had a trial of at least 120 days with the individual drugs **OR** must provide documentation of medical necessity beyond convenience for patient's inability to use the individual drugs

**ADDITIONAL INFORMATION**

- An inadequate clinical response is defined as the inability to reach A1C goal after at least 120 days of current regimen with documented adherence and appropriate dose escalation.
- Requests may be authorized for patients with a condition that is difficult to control (i.e., prone to ketoacidosis, hypoglycemia)
- For non-preferred drugs that have preferred drugs in the same drug class: must provide documentation that there was at least one inadequate clinical response with a drug in same drug class

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

## Endocrine Agents: Endometriosis

**LENGTH OF AUTHORIZATIONS:** 365 Days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**STEP THERAPY CRITERIA:**

- Must have had an inadequate clinical response of at least 84 days with at least one preferred NSAID and one preferred oral contraceptive

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 84 days with at least one preferred NSAID, one preferred oral contraceptive, **AND** one preferred step-therapy drug
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

## Endocrine Agents: Estrogenic Agents

**LENGTH OF AUTHORIZATIONS:** 365 Days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**ADDITIONAL INFORMATION:**

- Requests for non-preferred drugs must have an inadequate clinical response with preferred drugs with the same delivery method

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

## Endocrine Agents: Growth Hormone

**LENGTH OF AUTHORIZATIONS:** Initial: 180 days; Subsequent: 365 days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

### **CLINICAL PA CRITERIA:**

#### **Pediatric Approvals (under 18 years of age):**

- Must be treated and followed by a pediatric endocrinologist, nephrologist, clinical geneticist, endocrinologist, or gastroenterologist (or as appropriate for diagnosis)
- Must provide documentation to justify criteria being met, including height, weight, bone age (children), date and results of most current x-ray, stimulus test results, IGF-1 levels, and a growth chart (children)
- Must not be used in combination with another somatropin agent

#### **Adult Approvals (18 years of age or older):**

- Must be treated and followed by an endocrinologist
- Must provide documentation of growth hormone deficiency by means of a negative response to an appropriate stimulation test (clonidine test is not acceptable for adults)
- Must provide documentation of baseline evaluation of the following clinical indicators: (1) insulin-like growth factor (IGF-1); (2) fasting lipid profile; (3) BUN; (4) fasting glucose; (5) electrolytic levels; (6) evaluation of any new osteoarthritis and joint pain; (7) bone density test
- Must have had other hormonal deficiencies addressed with adequate replacement therapy

### **NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 90 days with at least one preferred drug
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

### **SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring (i.e., height, weight gain, improved body composition)  
For adults: must provide documentation by endocrinologist that discontinuing agent would have a detrimental effect on body composition or other metabolic parameters

## Endocrine Agents: Osteoporosis – Bone Ossification Enhancers

**LENGTH OF AUTHORIZATIONS:** 365 Days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least **365 days** with at least one preferred drug within the same class
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**ADDITIONAL ABALOPARATIDE (TYMLOS™) CRITERIA:**

- Must have had an inadequate clinical response of at least 365 days with one bisphosphonate

**ADDITIONAL INFORMATION**

- Patients should only be on ONE of the therapeutic classes (bisphosphonates, calcitonin-salmon)
- A total lifetime duration of therapy of 730 days with **any parathyroid analog** will be authorized

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

## Endocrine Agents: Progestin Agents

All products are covered without a PA

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## Endocrine Agents: Uterine Fibroids

**LENGTH OF AUTHORIZATIONS:** Up to 180 Days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**CLINICAL PA CRITERIA:**

- Must have had an inadequate clinical response of at least 90 days with at least one preferred oral contraceptive

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 90 days with at least one preferred drug
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**ADDITIONAL INFORMATION:**

- A total lifetime duration of therapy of 720 days **between** Oriahnn **and** Myfembree or 180 days for Lupron Depot will be authorized

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

## Gastrointestinal Agents: Anti-Emetics

**LENGTH OF AUTHORIZATIONS:** 365 Days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 7 days with at least one preferred drug
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

## Gastrointestinal Agents: Crohn's Disease

**LENGTH OF AUTHORIZATIONS:** 365 Days; **Ortikos ER – based on indication**

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

## Gastrointestinal Agents: Hepatic Encephalopathy

**LENGTH OF AUTHORIZATIONS:** 365 Days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**STEP THERAPY CRITERIA:**

- Must have had an inadequate clinical response of **at least 14 days** with at least one preferred drug

**RIFAXAMIN (XIFAXAN) CRITERIA:**

- Must have had an inadequate clinical response **of at least 14 days** to lactulose to be authorized for monotherapy or add on therapy

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- **Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs**
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

## Gastrointestinal Agents: Irritable Bowel Syndrome (IBS) with Diarrhea

**LENGTH OF AUTHORIZATIONS:** 365 Days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**STEP THERAPY CRITERIA:**

- Must have had an inadequate clinical response of at least **30 days** with at least one preferred drug

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least **30 days** with at least two preferred drugs
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

## Gastrointestinal Agents: Pancreatic Enzymes

**LENGTH OF AUTHORIZATIONS:** 365 Days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 14 days with at least one preferred drug
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

# Gastrointestinal Agents: Proton Pump Inhibitors

**LENGTH OF AUTHORIZATIONS:** 180 days, except as listed under additional criteria

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**ADDITIONAL CRITERIA FOR PPI DOSES GREATER THAN ONCE DAILY**

- For H. Pylori diagnosis: Must provide documentation of diagnosis
  - Authorization length: 30 days
- For any of the following diagnoses: carcinoma of GI tract, COPD, Crest Syndrome, dyspepsia, esophageal varices, gastritis, gastroparesis, scleroderma, symptomatic uncomplicated Barret's Esophagus, systemic mastocytosis, or Zollinger Ellison Syndrome: **Must provide documentation of diagnosis AND must have failed once-daily dosing of the requested drug**
  - Authorization length: 365 days

**ADDITIONAL INFORMATION**

- Request may be authorized If the drug was initiated in the hospital for the treatment of a condition such as a GI bleed or the presence of a gastrostomy and/or jejunostomy (G, GJ, J-tube)

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

**AR** - Protonix Pak/**Pantoprazole Packet**: a PA is required for patients 6 years and older

**AR** – Omeprazole & Pantoprazole Tab/Cap/ODT: a PA is required for patient 22 years and older requesting more than once daily dosing

## Gastrointestinal Agents: Ulcerative Colitis

**LENGTH OF AUTHORIZATIONS:** 365 Days; except Uceris foam – based on indication

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

**QL** – Budesonide ER 9mg tablets: 56 tablets per 90 days



## Gastrointestinal Agents: Unspecified GI

**LENGTH OF AUTHORIZATIONS:** 365 days except 3 days for Aemcolo

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**STEP THERAPY CRITERIA:**

- Must have had an inadequate clinical response to at least 14 days with at least two preferred drugs

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 14 days with at least three preferred drugs, if indicated for diagnosis
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**ADDITIONAL METHYLNALTREXONE (RELISTOR) AND NALDEMEDINE (SYMPROIC) CRITERIA:**

- Must have a history of chronic pain requiring continuous opioid therapy for ≥84 days

**ADDITIONAL RIFAMYCIN DELAYED-RELEASE (AEMCOLO) CRITERIA:**

Must have the inability to take, or failure of **ALL** of the following: a

**ADDITIONAL SOMATROPIN INJECTION (ZORBTIVE) AND TEDLOGLUTIDE (GATTEX) CRITERIA:**

- Must have evidence of specialized parenteral nutritional support
- Must have documentation of appropriate lab assessment (bilirubin, alkaline phosphatase, lipase, and amylase) at least 180 days prior to initiation

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring (i.e., decreased frequency of specialized nutrition support or improvement in symptoms)

# Genitourinary Agents: Benign Prostatic Hyperplasia

**LENGTH OF AUTHORIZATIONS:** 365 Days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**TADALAFIL (CIALIS) CRITERIA:**

- Must have had an inadequate clinical response of at least 30 days with at least one alpha-1 adrenergic blocker and at least 90 days of finasteride

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**ADDITIONAL DUTASTERIDE/TAMSULOSIN (JALYN) CRITERIA**

- Must provide documentation for patient's inability to use the individual drugs

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

## Genitourinary Agents: Electrolyte Depleter Agents

**LENGTH OF AUTHORIZATIONS:** 365 Days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 7 days with at least two preferred drugs
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

## Genitourinary Agents: Urinary Antispasmodics

**LENGTH OF AUTHORIZATIONS:** 365 Days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs with different active ingredients
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

**AR** – Vesicare LS: a PA is required for patients younger than 2 years old AND 5 years and older

**AR** – Myrbetriq Granules: a PA is required for patients younger than 3 years old AND 5 years and older

# Immunomodulator Agents: Systemic Inflammatory Disease

**LENGTH OF AUTHORIZATIONS:** Initial: 90 days; Subsequent: 365 days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**CLINICAL PA CRITERIA:**

- Must have been an inadequate clinical response of at least 90 days with at least two applicable first-line drugs indicated for diagnosis – provide documentation of the trialed drugs, dosages, dates, and durations
- Authorization of dosing regimens (loading/maintenance) will be based upon diagnosis. Document the requested loading and maintenance dosing on PA form, if applicable
- Must not have a current, active infection
- Must provide evidence of negative TB test prior to initiation of biologic therapy, if required by labeling

**STEP THERAPY CRITERIA:**

- Must have had an inadequate clinical response of at least 90 days with at least one preferred TNF inhibitor indicated for diagnosis

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 90 days with at least two preferred drugs, if indicated for diagnosis
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**ADDITIONAL ALOPECIA AREATA CRITERIA:**

- Must be prescribed by or in consultation with a specialist (i.e., dermatologist, rheumatologist)
- Must provide documentation of an inadequate clinical response of at least 90 days with a topical steroid

**ADDITIONAL ATOPIC DERMATITIS CRITERIA:**

- Must have at least 10% body surface area (BSA) involvement with two of the following: topical corticosteroids, or topical calcineurin inhibitors [e.g., Elidel], or topical PDE-4 inhibitors [e.g., ~~Eucrisa~~], unless atopic dermatitis is severe and involves >25% BSA

**ADDITIONAL PLAQUE PSORIASIS CRITERIA:**

- For patients currently receiving phototherapy, initial authorization for preferred drugs requires an inadequate clinical response to at least 90 days of phototherapy

**ADDITIONAL ULCERATIVE COLITIS CRITERIA:**

- If an inadequate clinical response after 90 days with one TNF inhibitor, further TNF inhibitors will not be authorized

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

# Infectious Disease Agents: Antibiotics – Cephalosporins

**LENGTH OF AUTHORIZATIONS:** Based on indication

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 3 days with at least one preferred antibiotic
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**ADDITIONAL INFORMATION**

- Requests may be authorized if:
  - The infection is caused by an organism resistant to **ALL** preferred antibiotics (must provide diagnosis and any culture/sensitivity results)
  - The patient is completing a course of therapy that was started in the hospital or other similar location or was started before Medicaid eligibility, **only the remaining course will be authorized**

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment, ongoing safety monitoring, **AND** medical necessity for continued use

**AR** - Cefaclor Suspension: a PA is required for patients 12 years and older

**AR** - Cefixime Suspension: a PA is required for patients 12 years and older

**AR** - Cefprozil Suspension: a PA is required for patients 12 years and older

**AR** - Suprax Chewable Tablet: a PA is required for patients 12 years and older

## Infectious Disease Agents: Antibiotics – Inhaled

**LENGTH OF AUTHORIZATIONS:** Initial: 180 days; Subsequent: 365 days

**ALL REQUESTS:** Must be prescribed in accordance with FDA approved labeling

**CLINICAL PA CRITERIA:**

- Must provide documentation of cultures demonstrating drug is prescribed in alignment with approved indication

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 28 days with at least one preferred drug
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring (i.e., culture conversion, symptom improvement)

**QL – Tobramycin drugs: 28 doses in 56 days**



## Infectious Disease Agents: Antibiotics – Macrolides

**LENGTH OF AUTHORIZATIONS:** Based on indication

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 3 days with at least one preferred drug
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**ADDITIONAL INFORMATION**

- Requests may be authorized if:
  - The infection is caused by an organism resistant to **ALL** preferred antibiotics (must provide diagnosis and any culture/sensitivity results)
  - The patient is completing a course of therapy that was started in the hospital or other similar location or was started before Medicaid eligibility, **only the remaining course will be authorized**

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment, ongoing safety monitoring, **AND** medical necessity for continued use

## Infectious Disease Agents: Antibiotics – Quinolones

**LENGTH OF AUTHORIZATIONS:** Based on indication

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 3 days with at least one preferred drug
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**ADDITIONAL INFORMATION**

- Requests may be authorized if:
  - The infection is caused by an organism resistant to **ALL** preferred antibiotics (must provide diagnosis and any culture/sensitivity results)
  - The patient is completing a course of therapy that was started in the hospital or other similar location or was started before Medicaid eligibility, **only the remaining course will be authorized**

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment, ongoing safety monitoring, **AND** medical necessity for continued use

**AR** - Ciprofloxacin Suspension: a PA is required for patients 12 years and older

## Infectious Disease Agents: Antibiotics – Tetracyclines

**LENGTH OF AUTHORIZATIONS:** Based on indication for acute infections or 365 days for acne

**ALL REQUESTS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 3 days with at least one preferred drug for acute infections **OR** at least 90 days with at least one preferred oral drug for acne
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**ADDITIONAL INFORMATION**

- Requests may be authorized if:
  - The infection is caused by an organism resistant to **ALL** preferred antibiotics (must provide diagnosis and any culture/sensitivity results)
  - The patient is completing a course of therapy that was started in the hospital or other similar location or was started before Medicaid eligibility, only the remaining course will be authorized

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment, ongoing safety monitoring, **AND** medical necessity for continued use

**AR** – Vibramycin Suspension: a PA is required for patients 12 years and older

**AR** – Doxycycline Syrup: a PA is required for patients 12 years and older

# Infectious Disease Agents: Antifungals

**LENGTH OF AUTHORIZATIONS:** Based on indication

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 7 days with at least one preferred drug
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**ADDITIONAL INFORMATION**

- Requests may be authorized if:
  - The infection is caused by an organism resistant to **ALL** preferred antifungals (must provide diagnosis and any culture/sensitivity results)
  - The patient is completing a course of therapy that was started in the hospital or other similar location or was started before Medicaid eligibility, **only the remaining course will be authorized**
  - ~~If the request is for a diagnosis other than fungal infection, please refer the case to a pharmacist. An off label use may be approvable for a medication such as Nizoral for advanced prostate cancer or for Cushing's Syndrome when standard treatments have failed~~

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment, ongoing safety monitoring, **AND** medical necessity for continued use

## Infectious Disease Agents: Antivirals – Hepatitis C Agents

**LENGTH OF AUTHORIZATIONS:** Dependent upon authorized course

**ALL REQUESTS:** Must be prescribed in accordance with FDA approved labeling\_

**CLINICAL PA CRITERIA:**

- Only regimens recommended by the American Association for the Study of Liver Diseases (AASLD) will be authorized
- Please see the Hepatitis C Direct Acting Antiviral Prior Authorization Form for criteria

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response defined as not achieving SVR with guideline-recommended preferred drugs
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**ADDITIONAL INFORMATION:**

- Requests for patients established on current therapy with prior payer (i.e., Commercial, Fee-for-Service, Managed Care Plan, etc) will be authorized with documentation
- Requests for regimens including pegylated Interferons must include close monitoring with periodic clinical and laboratory evaluations
- Requests for regimens including ribavirins must include documentation of at least two reliable forms of contraception being used during therapy

## Infectious Disease Agents: Antivirals – Herpes

**LENGTH OF AUTHORIZATIONS:** For the duration of the prescription (up to 180 days)

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 3 days with at least one preferred drug
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

## Infectious Disease Agents: Antivirals – HIV\*

**LENGTH OF AUTHORIZATIONS:** 365 Days

**GRANDFATHERING\*:**

Patients who have a claim for a non-preferred drug in the previous 120 days will be automatically approved to continue the drug. Patients who have taken the drug previously, but do not have claims history (e.g., new to Medicaid), will need to submit a prior authorization in order to continue coverage.

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**FOSTEMSAVIR (RUKOBIA ER) CRITERIA:**

- ~~Must provide documentation of a multidrug-resistant HIV-1 infection~~

**ABACAVIR/DOLUTEGRAVIR/LAMIVUDINE (TRIUMEQ PD) CRITERIA:**

- Must provide documentation of patient's weight (only authorized for those 10 – 25 kg)

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least one preferred drug. If applicable, the request must address the inability to use the individual components.
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**ADDITIONAL DARUNAVIR/COBICISTAT/EMTRICITABINE/TENOFOVIR (SYMTUZA) CRITERIA:**

- Must provide documentation for patient's inability to use the individual drugs

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

**AR** – Isentress chewable tablet: a PA is required for patients 12 years and older

**AR** – Lamivudine solution: a PA is required for patients 3 years and older

**AR** – Nevirapine solution: a PA is required for patients 3 years and older

# Ophthalmic Agents: Antibiotic and Antibiotic-Steroid Combination Drops and Ointments

**LENGTH OF AUTHORIZATIONS:** 30 days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 3 days with at least two preferred drugs
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**ADDITIONAL INFORMATION**

- Requests may be authorized if:
  - The infection is caused by an organism resistant to **ALL** preferred antibiotics (must provide diagnosis and any culture/sensitivity results)
  - The patient is completing a course of therapy that was started in the hospital or other similar location or was started before Medicaid eligibility, **only the remaining course will be authorized**



## Ophthalmic Agents: Antihistamines & Mast Cell Stabilizers

**LENGTH OF AUTHORIZATIONS:** 365 Days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

## Ophthalmic Agents: Dry Eye Treatments

**LENGTH OF AUTHORIZATIONS:** 14 Days for Eysuvis; 365 Days for all other drugs

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**STEP THERAPY CRITERIA:**

- Must have had an inadequate clinical response of at least 14 days with one artificial tear or OTC dry eye drop in the previous 120 days

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 14 days with at least one preferred drug
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

## Ophthalmic Agents: Glaucoma Agents

**LENGTH OF AUTHORIZATIONS:** 365 Days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**STEP THERAPY CRITERIA:**

- Must have had an inadequate clinical response of at least 30 days with at least one preferred drug **in the same class, if available**

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs **in the same class, if available**
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

## Ophthalmic Agents: NSAIDs

**LENGTH OF AUTHORIZATIONS:** 30 days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling\_

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 3 days with at least one preferred drug
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

## Ophthalmic Agents: Ophthalmic Steroids

**LENGTH OF AUTHORIZATIONS:** 30 days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

## Otic Agents: Antibacterial and Antibacterial/Steroid Combinations

**LENGTH OF AUTHORIZATIONS:** 30 days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 7 days with at least one preferred drug
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

## Respiratory Agents: Antihistamines – Second Generation

**LENGTH OF AUTHORIZATIONS:** 365 Days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least two different preferred drugs
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

**AR** – Cetirizine Chewables: a PA is required for patients 6 years and older

# Respiratory Agents: Cystic Fibrosis

**LENGTH OF AUTHORIZATIONS:** Initial: 90 days; Subsequent: 365 days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**CLINICAL PA CRITERIA:**

- Must be prescribed by or in consultation with a pulmonologist or infectious disease specialist
- Must provide documentation of the genetic mutation

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least **30 days** with at least **one preferred drug**
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**ADDITIONAL BRONCHITOL CRITERIA:**

- Must be used as an add-on maintenance therapy
- Must provide documentation of a completed Bronchitol Tolerance Test

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment (adherence to treatment demonstrated by claims history **AND** one or more of the following: FEV1, weight gain, sweat chloride, pulmonary exacerbations, etc.) and ongoing safety monitoring



## Respiratory Agents: Epinephrine Auto-Injectors

**LENGTH OF AUTHORIZATIONS:** 365 Days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response to at least one preferred drug
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

# Respiratory Agents: Hereditary Angioedema

**LENGTH OF AUTHORIZATIONS:** Initial: 90 days; Subsequent: 180 Days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**CLINICAL PA CRITERIA:**

- Must provide documentation of diagnosis (i.e., C1-INH deficiency or dysfunction (Type I or II HAE)) and whether the drug will be used for prophylaxis or treatment
- Must provide documentation of at-home administration

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least **60 days** with at least one preferred drug
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

# Respiratory Agents: Inhaled Agents

**LENGTH OF AUTHORIZATIONS:** 365 Days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs within the same class **and duration of action**
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**ADDITIONAL STEROID-CONTAINING INHALER CRITERIA**

- May be authorized if documentation of one of the following is provided:
  - Patient is 12 years or younger OR is disabled and is unable to use a preferred inhaler
  - Patient has been non-compliant on a preferred inhaler due to taste, dry mouth, or infection
  - Patient is clinically unstable, as defined by current guidelines in terms of oral steroid use or patient's current symptomatology

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

**AR** - Albuterol Nebulizer Solution 0.021% (0.63mg/3mL), 0.042% (1.25mg/3mL): a PA is required for patients 13 years and older

**AR** - Budesonide Nebulizer Solution: a PA is required for patients 7 years and older

# Respiratory Agents: Leukotriene Receptor Modifiers & Inhibitors

**LENGTH OF AUTHORIZATIONS:** 365 Days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**STEP THERAPY CRITERIA:**

- Must have had an inadequate clinical response of at least 90 days with at least one preferred drug

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 90 days with at least two preferred drugs
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

# Respiratory Agents: Monoclonal Antibodies-Anti-IL/Anti-IgE

**LENGTH OF AUTHORIZATIONS:** Initial: 180 days; Subsequent: 365 days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

## **CLINICAL PA CRITERIA:**

- Must be prescribed by or in consultation with an applicable specialist (i.e., allergist/immunologist, pulmonologist, or otolaryngologist)
- For **Asthma** – Must have had uncontrolled asthma symptoms and/or exacerbations despite at least 30 days with:
  - Medium dose preferred ICS/LABA inhaler for 6 years and older **OR** medium dose preferred ICS/LABA inhaler with tiotropium or high dose ICS/LABA inhaler if 12 years and older
- For **Chronic Rhinosinusitis with Nasal Polyposis** – Must have had an inadequate clinical response of at least 30 days to at least one oral corticosteroid AND one nasal corticosteroid spray
- For **Chronic Urticaria** – Must have had an inadequate clinical response to at least 14 days with at least two different antihistamines

## **NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 90 days with at least one preferred drug
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics, requests must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

## **SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring (i.e., PFT improvement, reduced affected BSA)

## Respiratory Agents: Nasal Preparations

**LENGTH OF AUTHORIZATIONS:** 365 days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs **in the same class, if available**
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

## Respiratory Agents: Other Agents

**LENGTH OF AUTHORIZATIONS:** Initial: 90 days; Subsequent: 180 days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 90 days with at least one preferred long-acting beta agonist AND one preferred long-acting muscarinic antagonist-containing inhalers
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**ADDITIONAL ROFLUMILAST (DALIRESP) CRITERIA:**

- Must be used in addition to a long-acting beta agonist **AND** a long-acting muscarinic antagonist-containing inhalers

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment, adherence to maintenance inhaler per pharmacy claims, and ongoing safety monitoring

## Topical Agents: Antifungals

**LENGTH OF AUTHORIZATIONS:** Up to 180 days for all agents except 365 days for Jublia

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs, if indicated for diagnosis
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**ADDITIONAL EFINACONAZOLE (JUBLIA) CRITERIA:**

- Must have had an inadequate clinical response of at least 365 days with at least one preferred topical drug **AND** at least 84 days with at least one preferred oral drug indicated for diagnosis

**ADDITIONAL INFORMATION**

- Requests may be authorized if:
  - The infection is caused by an organism resistant to preferred antibiotics drugs (note diagnosis and any culture/sensitivity results)

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring



## Topical Agents: Antiparasitics

**LENGTH OF AUTHORIZATIONS:** 14 Days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least **14 days** with at least one preferred drug
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

## Topical Agents: Corticosteroids

**LENGTH OF AUTHORIZATIONS:** 365 days for low/med potency; 90 days for high/very high potency

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

## Topical Agents: Immunomodulators

**LENGTH OF AUTHORIZATIONS:** 365 Days

**ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling

**STEP THERAPY CRITERIA:**

- Must have had an inadequate clinical response of at least 30 days with at least two topical corticosteroids

**NON-PREFERRED CRITERIA:**

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least one preferred drug
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

**SUBSEQUENT AUTHORIZATION CRITERIA:**

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

**AR** - pimecrolimus and tacrolimus: a PA is required for patients younger than 2 years old